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CHANGE TITLE: EVOLVING PRACTICES 16-004

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REMOVE PAGE(S)

CHAPTER 1

Section 3.1, pages 3 and 4

Section 12.1, pages 1 and 2

CHAPTER 4

Section 6.1, pages 1 through 4

Section 13.1, pages 1 through 3

Section 21.1, pages 1 and 2

CHAPTER 5

Section 1.1, pages 5 through 8

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CHAPTER 7

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 3.1. This change confirms the Off Label Use of Rituximab Injections for the Treatment of Stiff Person Syndrome. EFFECTIVE DATE: 03/31/2005.
2. Section 12.1.
 - a. This change adds Category III codes 0249T as covered services for Transanal Hemorrhoidal Dematerialization to be used in the treatment of hemorrhoids. EFFECTIVE DATE: 10/28/2013.
 - b. This change adds Category III 0346T for the use of transient elastography in the detection and monitoring of hepatic cirrhosis for patients with chronic hepatitis. EFFECTIVE DATE: 12/09/2014.

CHAPTER 4

3. Section 6.1. This change establishes two-level cTDR for the treatment of DDD, intractable radiculopathy, and/or myelopathy is proven safe and effective. EFFECTIVE DATE: 07/27/2015.
4. Section 13.1. This change confirms that Transanal Hemorrhoidal Dematerialization may be used as an alternative to conventional internal hemorrhoidectomy for the treatment of grade II to IV hemorrhoids. EFFECTIVE DATE: 10/28/2013.
5. Section 21.1. This change confirms Canaloplasty for the treatment of primary open-angle glaucoma is covered, and removes the previous procedure codes for Canaloplasty for the treatment of glaucoma. EFFECTIVE DATE: 02/14/2015.

CHAPTER 5

6. Section 1.1. This change confirms that the use of transient elastography for the detection and monitoring of hepatic cirrhosis in patients with chronic hepatitis C is covered. EFFECTIVE DATE: 12/09/2014.
7. Section 4.1. This change clarifies that PET and PET/CT for the initial diagnosis, staging, and monitoring of treatment of ovarian cancer is covered. EFFECTIVE DATE: 02/01/2015.

CHAPTER 7

8. Section 6.1. This change removes language regarding Canaloplasty in the treatment of glaucoma being unproven. EFFECTIVE DATE: 02/14/2015.
9. Section 15.1. This change confirms the Off label-use of Rituximab Injections for the Treatment of Stiff Person Syndrome. EFFECTIVE DATE: 03/31/2005.

3.2 for policy regarding brachytherapy/radiation therapy.

2.13 Radiofrequency Ablation (RFA), when performed using an U.S. Food and Drug Administration (FDA) approved electrosurgical cutting and coagulation device, may be considered for cost-sharing for the treatment of liver metastases from gastric cancer. The effective date is June 1, 2010.

2.14 Effective September 1, 2012, the NovoTTF-100A system (HCPCS A4555 and E0766) may be cost-shared for treatment of adult patients (22 years of age or older) with recurrent glioblastoma after surgical and radiation options have been exhausted.

2.15 Effective February 4, 2011, Radiesse® Voice laryngoplasty injections may be cost-shared for the treatment of type 1 laryngeal cleft (also described as supraglottic interarytenoid defects that extend no further than the true vocal folds).

2.16 Effective November 27, 1995, Orthotopic Liver Transplantation (OLT) may be cost-shared for the treatment of Crigler-Najjar Syndrome Type I. OLT may be performed both prior to the onset of neurological symptoms or after the onset of neurological symptoms.

2.17 Effective June 5, 2013, off-label use of intravenous immune globulin for the treatment of Hashimoto's Encephalopathy, may be considered in exceptional circumstances where there is progressive neurologic decline despite appropriate steroid therapy or where steroid therapy is contraindicated.

2.18 Effective April 30, 2009, Intrapulmonary Percussive Ventilation (IPV) may be considered for cost-sharing when the diagnosis is Cystic Fibrosis (CF). See [Chapter 8, Section 16.1](#) for policy regarding IPVs.

2.19 Effective January 4, 2013, allogeneic hematopoietic cell transplant (CPT² procedure code 38240) for the treatment of primary plasma cell leukemia.

2.20 Off-label use of Photodynamic Therapy (CPT² procedure code 67221) with Visudyne (HCPCS J3396) may be considered for cost-sharing for the treatment of retinal astrocytic hamartoma in Tuberous Sclerosis. The effective date is February 1, 2008.

2.21 Effective June 25, 2014, intracranial angioplasty with stenting (CPT² procedure code 61635) of the venous sinuses may be considered for cost-sharing for the treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension).

2.22 Effective February 1, 2012, OLT (CPT² procedure code 47135) for the treatment of Acute Intermittent Porphyria.

2.23 Effective December 1, 2014, Photodynamic Therapy for the treatment of Central Serous Chorioretinopathy.

2.24 Effective March 31, 2005, off-label use of rituximab injections may be considered for cost-sharing for the treatment of Stiff Person Syndrome.

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3.0 EXCLUSIONS

3.1 The off-label use of rituximab for the treatment of pediatric linear Immunoglobulin A (IgA) dermatosis is unproven.

3.2 Proton Beam Therapy (PBT)/radiosurgery/radiotherapy for the treatment of thymoma is unproven.

3.3 TRICARE Overseas Program (TOP) beneficiaries are not subject to the requirements of this policy.

- END -

Category III Codes

Issue Date: March 6, 2002

Authority: [32 CFR 199.2\(b\)](#) and [32 CFR 199.4\(g\)\(15\)](#)

1.0 CPT¹ PROCEDURE CODES

0073T, 0075T, 0076T, 0099T, 0184T, 0308T

2.0 DESCRIPTION

Category III codes are a set of temporary codes for emerging technology, services, and procedures. These codes are used to track new and emerging technology to determine applicability to clinical practice. When a Category III code receives a Category I code from the American Medical Association (AMA) it does not automatically become a benefit under TRICARE. However, the codes that may have moved from unproven to proven must be forwarded to the Office of Medical Benefits and Reimbursement Branch (MB&RB) for coverage determination/policy clarification.

3.0 POLICY

3.1 Category III codes are to be used instead of unlisted codes to allow the collection of specific data. TRICARE has not opted to track Category III codes at this time.

3.2 Category III codes are excluded from coverage since clinical safety and efficacy or applicability to clinical practice has not been established.

4.0 EXCEPTIONS

4.1 U.S. Food and Drug Administration (FDA) Investigational Device Exemption (IDE) (Category B) clinical trial. See [Chapter 8, Section 5.1](#).

4.2 Category III code 0073T is a covered service as listed in [Chapter 5, Section 3.1](#).

4.3 Category III codes 0075T and 0076T are covered codes as outlined in [Chapter 4, Section 9.1](#).

4.4 Category III codes 0099T and 0308T are covered codes as outlined in [Chapter 4, Section 21.1](#).

4.5 Category III code 0184T is a covered service as listed in [Chapter 4, Section 13.1](#).

4.6 Category III code 0249T is a covered service as listed in [Chapter 4, Section 13.1](#).

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4.7 Category III code 0346T is a covered service as listed in Chapter 5, Section 1.1.

5.0 EXCLUSIONS

5.1 Unlisted codes for Category III codes. Effective January 1, 2002.

5.2 Ultrasound ablation (destruction of uterine fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT² procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

5.3 Computer-Aided Detection (CAD) with breast MRI (CPT² procedure code 0159T) is unproven.

5.4 XSTOP Interspinous Process Decompression System (CPT² procedure codes 0171T and 0172T, HCPCS code C1821) is unproven.

5.5 Ultrasound-guided facet joint injection (CPT² procedure codes 0216T and 0217T) is unproven.

- END -

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Musculoskeletal System

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#) and [\(c\)\(3\)](#)

1.0 CPT¹ PROCEDURE CODES

20005 - 20551, 20555 - 22328, 22510 - 22515, 22532 - 22856, **22858**, 22861, 22864 - 27138, 27146 - 27178, 27181 - 29861, 29870 - 29913, 29999

2.0 HCPCS CODES

S2118, S2325, S2360, S2361

3.0 DESCRIPTION

The musculoskeletal system pertains to or comprises the skeleton and the muscles.

4.0 POLICY

4.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered. U.S. Food and Drug Administration (FDA) approved surgically implanted devices are also covered.

4.2 Effective August 25, 1997, Autologous Chondrocyte Implantation (ACI) surgery for the repair of clinically significant, symptomatic, cartilaginous defects of the femoral condyle (medial, lateral or trochlear) caused by acute or repetitive trauma is a covered procedure. The autologous cultured chondrocytes must be approved by the FDA.

4.3 Single or multilevel anterior cervical microdiscectomy with allogeneic or autogeneic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

4.4 Percutaneous vertebroplasty (CPT¹ procedure codes 22510-22512, S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes 22513-22515) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

4.5 Total Ankle Replacement (TAR) (CPT¹ procedure codes 27702 and 27703) surgery is covered if the device is FDA approved and the use is for an FDA approved indication. However, a medical necessity review is required in case of marked varus or valgus deformity.

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4.6 Core decompression of the femoral head (hip) for early (precollapse stage I or II) avascular necrosis may be considered for cost-sharing (Healthcare Common Procedure Coding System (HCPCS) code S2325).

4.7 Single-level, cervical Total Disc Replacement (cTDR) (CPT² procedure code 22856) and two-level cTDR (CPT² procedure code 22858) using an FDA approved cervical artificial intervertebral disc for the treatment of cervical DDD, intractable radiculopathy, and/or myelopathy is covered if the disc is used in accordance with its FDA labeled indications.

4.8 High Energy Extracorporeal Shock Wave Therapy (HE ESWT) for the treatment of plantar fasciitis is covered when all of the following conditions are met:

- Patients have chronic plantar fasciitis of at least six months duration;
- Patients have undergone and failed six months of appropriate conservative therapy; and
- HE ESWT is defined as Energy Flux Density (EFD) greater than 0.12 millijoules per square millimeter (mJ/mm²).

4.9 Meniscal allograft transplant of the knee is covered.

4.10 Hip resurfacing (CPT² procedure codes 27125 and 27130, and HCPCS S2118) with an FDA approved device is proven for the treatment of Degenerative Joint Disease (DJD) of the hip in patients who are less than 65 years old and who meet all of the following criteria:

- Have chronic, persistent pain and/or disability;
- Are otherwise healthy and active;
- Have normal proximal femoral bone geometry and bone quality; and
- Would otherwise receive a conventional Total Hip Replacement (THR), but are likely to outlive a conventional THR implant system's expected life.

5.0 EXCLUSIONS

5.1 Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.

5.2 Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.

5.3 Trigger point injection (CPT² procedure codes 20552 and 20553) for migraine headaches.

5.4 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), three or more levels (CPT² procedure code 0375T) is unproven.

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Chapter 4, Section 6.1

Musculoskeletal System

5.5 Removal of total disc arthroplasty (artificial disc), anterior approach, cervical, each additional interspace (CPT³ procedure code 0095T) is unproven. Also, see [Section 1.1](#).

5.6 Lumbar total disc arthroplasty (lumbar artificial intervertebral disc revision including replacement, lumbar total disc replacement) for degenerative disc disease is unproven (CPT³ procedure codes 22857, 22862, 0163T, 0164T, and 0165T).

5.7 Low Energy (LE) or radial ESWT for the treatment of plantar fasciitis is unproven. Any form of ESWT for the treatment of lateral epicondylitis is unproven.

5.8 XSTOP Interspinous Process Decompression System (CPT³ procedure codes 0171T and 0172T, HCPCS code C1821) for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

5.9 Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT³ procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

5.10 Hip arthroscopy with debridement of articular cartilage (CPT³ procedure code 29862) for the treatment of FAI is unproven.

5.11 Hip arthroscopy with femoroplasty (CPT³ procedure code 29914) treatment of FAI; cam lesion is unproven.

5.12 Hip arthroscopy with acetabuloplasty (CPT³ procedure code 29915) treatment of FAI; pincer lesion is unproven.

5.13 Hip arthroscopy with labral repair (CPT³ procedure code 29916) for treatment of FAI syndrome is unproven.

5.14 Osteochondral allograft of the humeral head with meniscal transplant and glenoid microfracture in the treatment of shoulder pain and instability is unproven.

5.15 Thermal Intradiscal Procedures (TIPs) (CPT³ procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (IDTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as Percutaneous Radiofrequency (RF) Thermomodulation or Percutaneous Plasma Discectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

5.16 Spinal manipulation under anesthesia (CPT³ procedure codes 00640 and 22505) for the treatment of back pain is unproven.

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Musculoskeletal System

5.17 Minimally Invasive Lumbar Decompression (mild®) for the treatment of Degenerative Disc Disease (DDD) and/or spinal stenosis is unproven.

5.18 ACI surgery for the repair of patellar cartilage lesions is unproven.

5.19 iFuse Implant System (CPT⁴ procedure code 27279) for treatment of sacroiliac joint pain is unproven.

5.20 Athletic pubalgia surgery is unproven.

6.0 EFFECTIVE DATES

6.1 February 6, 2006, for percutaneous vertebroplasty and balloon kyphoplasty.

6.2 May 1, 2008, for TAR.

6.3 May 1, 2008, for core decompression of the femoral head.

6.4 December 24, 2012, for single-level, cTDR using an FDA approved cervical artificial intervertebral disc.

6.5 December 2, 2013, for HE ESWT for plantar fasciitis.

6.6 May 1, 2015, for meniscal allograft transplant of the knee.

6.7 May 21, 2014, for hip resurfacing for treatment of DJD of the hip.

6.8 July 27, 2015, for two-level cTDR using an FDA approved cervical artificial intervertebral disc.

- END -

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Chapter 4

Section 13.1

Digestive System

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#) and [\(c\)\(3\)](#)

1.0 CPT¹ PROCEDURE CODES

40490 - 40831, 40899 - 43644, 43647, 43648, 43651 - 43761, 43800, 43810, 43820, 43842, 43846, 43848, 43880 - 43882, 43999, 44005 - 47362, 47370, 47371, 47379 - 47382, 47399 - 49999, 91123, 96570, 96571

2.0 DESCRIPTION

The digestive system involves the organs associated with the ingestion, digestion, and absorption of nutrients, and the elimination of solid waste.

3.0 POLICY

3.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the digestive system are covered.

3.2 Gastric electrical stimulation (CPT¹ procedure codes 43647, 43648, 43881, and 43882) for treatment of symptoms of nausea and vomiting from chronic gastroparesis that is refractory to medical management may be considered for coverage as a Humanitarian Use Device (HUD).

3.3 Radiofrequency Ablation (RFA) (CPT¹ procedure codes 47370, 47380, and 47382) for treatment of unresectable hepatocellular carcinoma or unresectable liver metastases from colorectal cancer is proven and may be covered when all of the following conditions are met:

- Tumors are less than five centimeters in diameter;
- There are five or fewer tumors; and
- There is no evidence of extrahepatic metastasis.

Note: All procedures must be performed using an U.S. Food and Drug Administration (FDA) approved electrosurgical cutting and coagulation device.

3.4 Intraperitoneal Hyperthermic Chemotherapy (IPHC) (CPT¹ procedure codes 77600, 77605, and 96445) in conjunction with cytoreductive surgery or peritonectomy for treatment of

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pseudomyxoma peritonei resulting from appendiceal carcinoma may be covered under the Rare Diseases policy on a case-by-case basis for adult patients when all of the following criteria are met:

- There is no evidence of distant metastasis.
- There is evidence of low histological aggressiveness of the disease.
- The patient's condition does not preclude major surgery.
- The chemotherapeutic agents used are mitomycin C, cisplatin (also known as cisplatinum), or fluorouracil.

3.5 Transanal Endoscopic Microsurgery (TEM) (CPT² procedure code 0184T) for treatment of benign lesions or malignant T1 tumors is proven and may be covered when all of the following criteria are met:

- The lesion can be adequately identified in the rectum and is a mobile, non-fixed benign lesion or T1 tumor with a diameter less than three centimeters that covers less than 30% of the circumference of the bowel, located within eight centimeters of the anal verge.
- Pretreatment endorectal ultrasonography indicates an absence of lymphadenopathy and microscopic angiolymphatic invasion.
- The tumor is a moderately or well differentiated grade I, with no lymphatic, vascular, or perineural invasion.
- Resection margins are negative for greater than three millimeters.
- There is no evidence of distant metastasis.

3.6 Transanal Hemorrhoidal Dearterialization (THD) (CPT² procedure code 0249T) as an alternative to conventional internal hemorrhoidectomy for the treatment of grade II to IV hemorrhoids is proven.

4.0 EXCLUSIONS

4.1 Vestibuloplasty (CPT² procedure codes 40840 - 40845) EXCEPT for adjunctive dental care (see [Chapter 8, Section 13.1](#)).

4.2 The Stretta System (Curon Medical, Sunnyvale, CA), Bard Endoscopic Suturing System, and Transoral Incisionless Fundoplication using EsophyX (EndoGastric Solutions, Redmond, WA) for the treatment of refractory Gastro-Esophageal Reflux Disease (GERD) are unproven (CPT² procedure codes 43201 and 43257).

4.3 For bariatric procedures, see [Section 13.2](#).

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4.4 RFA for treatment of liver metastases from primary sites other than colorectal metastases is unproven (CPT³ procedure codes 47370, 47380, and 47382).

4.5 Cytoreductive Surgery (CRS) for Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for treatment of Peritoneal Carcinomatosis (PC) from colorectal cancer.

5.0 EFFECTIVE DATES

5.1 RFA (CPT³ procedure codes 47370, 47380, and 47382) for treatment of unresectable hepatocellular carcinoma or unresectable liver metastases from colorectal cancer is proven and covered, effective April 28, 2004.

5.2 IPHC (CPT³ procedure codes 77600, 77605, and 96445) in conjunction with cytoreductive surgery or peritonectomy for treatment of pseudomyxoma peritonei arising from appendiceal carcinoma may be covered under the Rare Diseases policy on a case-by-case basis for adult patients, effective May 13, 2009.

5.3 TEM (CPT³ procedure code 0184T) for treatment of benign lesions or malignant T1 tumors is covered effective June 2, 2009.

5.4 THD (CPT³ procedure code 0249T) is covered effective October 28, 2013.

- END -

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Chapter 4

Section 21.1

Eye And Ocular Adnexa

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#), [\(c\)\(3\)](#) and [\(g\)\(46\)](#)

1.0 CPT¹ PROCEDURE CODES

0192T, 0308T, 65091 - 65755, 65772 - 66175, 66180 - 68899, 77600 - 77615

2.0 DESCRIPTION

The eye is the organ of vision and the ocular adnexa are the appendages or adjunct parts; i.e., eyelids, lacrimal apparatus.

3.0 POLICY

3.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the eye or ocular adnexa are covered.

3.2 Phototherapeutic Keratectomy (PTK) is covered for corneal dystrophies.

3.3 Strabismus. Surgical procedures and eye examinations to correct, treat, or diagnose strabismus are covered.

3.4 Corneal transplants. A corneal transplant (keratoplasty) is a covered surgical procedure. Relaxing keratotomy to relieve astigmatism following a corneal transplant is covered.

3.5 Transpupillary thermotherapy (laser hyperthermia, CPT¹ procedure codes 77600 - 77615), with chemotherapy, is covered for the treatment of retinoblastoma. See also [Chapter 5, Section 5.1](#).

3.6 Intrastromal Corneal Ring Segments (Intacs[®]) is covered for U.S. Food and Drug Administration (FDA) approved indications for beneficiaries with keratoconus who meet all of the following criteria: (1) are unable to achieve adequate vision using lenses or spectacles; and (2) for whom corneal transplant is the only remaining option. Coverage allowed effective July 17, 2005.

3.7 Optonal ExPRESS Mini glaucoma Shunt (CPT¹ procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.

3.8 Off-label use of Photodynamic Therapy (CPT¹ procedure code 67221) with Visudyne (HCPCS J3396) may be considered for cost-sharing for the treatment of retinal astrocytic hamartoma in Tuberous Sclerosis. The effective date is February 1, 2008.

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3.9 Transpupillary thermotherapy (CPT² procedure code 67299) with Plaque Radiotherapy (Brachytherapy) is covered for the treatment of choroidal melanoma. See also [Chapter 5, Section 3.2](#).

3.10 Photodynamic Therapy for the treatment of Central Serous Chorioretinopathy in accordance with the TRICARE provisions for the treatment of rare diseases.

3.11 Implantable Miniature Telescope (IMT) is covered for FDA approved indications for beneficiaries with end-stage age-related macular degeneration.

3.12 Canaloplasty for the treatment of primary open angle glaucoma (CPT² procedure codes 66174 and 66175) is covered.

4.0 EXCLUSIONS

4.1 Refractive corneal surgery except as noted in [paragraph 3.4](#) (CPT² procedure codes 65760, 65765, 65767, 65770, 65771).

4.2 Eyeglasses, and contact lenses except as noted in [Chapter 7, Section 6.2](#).

4.3 Orthokeratology.

4.4 Orthoptics, also known as visual training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT² procedure code 92065).

4.5 Epikeratophakia for treatment of aphakia and myopia is unproven.

4.6 Transpupillary thermotherapy (CPT² procedure code 67299) as primary treatment of choroidal melanoma is unproven.

4.7 Autologous serum eye drops for the treatment of dry eye syndrome, keratitis, or ocular hypertension is unproven.

5.0 EFFECTIVE DATES

5.1 April 1, 2011, coverage for Optonal ExPRESS Mini Glaucoma Shunt.

5.2 December 1, 2014, coverage for Photodynamic Therapy for Central Serous Chorioretinopathy.

5.3 February 14, 2015, coverage for Canaloplasty for the treatment of glaucoma.

5.4 June 17, 2015, coverage date for IMT.

- END -

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4.12.3 Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors for osteoporosis are those identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG).

4.13 Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT⁴ procedure code 72291) or under CT guidance (CPT⁴ procedure code 72292) is covered.

4.14 Multislice or multidetector row CT angiography (CT, heart) (CPT⁴ codes 75571 - 75574) is covered for the following indications:

4.14.1 Evaluation of heart failure of unknown origin when invasive coronary angiography +/- Percutaneous Coronary Intervention (PCI) is not planned, unable to be preformed or is equivocal.

4.14.2 In an Emergency Department (ED) for patients with acute chest pain, but no other evidence of cardiac disease (low-pretest probability), when results would be used to determine the need for further testing or observation.

4.14.3 Acute chest pain or unstable angina when invasive coronary angiography or a PCI cannot be performed or is equivocal.

4.14.4 Chronic stable angina and chest pain of uncertain etiology or other cardiac findings prompting evaluation for CAD (for example: new or unexplained heart failure or new bundle branch block).

4.14.4.1 When invasive coronary angiography or PCI is not planned, unable to be performed, or is equivocal; AND

4.14.4.2 Exercise stress test is unable to be performed or is equivocal; AND

4.14.4.3 At least one of the following non-invasive tests were attempted and results could not be interpreted or where equivocal or none of the following tests could be performed:

4.14.4.3.1 Exercise stress echocardiography.

4.14.4.3.2 Exercise stress echo with dobutamine.

4.14.4.3.3 Exercise myocardial perfusion (SPECT).

4.14.4.3.4 Pharmacologic myocardial perfusion (SPECT).

4.14.5 Evaluation of anomalous native coronary arteries in symptomatic patients when conventional angiography is unsuccessful or equivocal and when results would impact treatment.

4.14.6 Evaluation of complex congenital anomaly of coronary circulation or of the great vessels.

4.14.7 Presurgical evaluation prior to biventricular pacemaker placement.

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4.14.8 Presurgical evaluation of coronary anatomy prior to non-coronary surgery (valve placement or repair; repair of aortic aneurysm or dissection).

4.14.9 Presurgical cardiovascular evaluation for patients with equivocal stress study prior to kidney or liver transplantation.

4.14.10 Presurgical evaluation prior to electrophysiologic procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

4.15 Transient elastography (TE) (ultrasound-based transient elastography or FibroScan®) (CPT⁵ procedure codes 0346T and 91200) for the detection and monitoring of hepatic cirrhosis in patients with chronic hepatitis C is covered.

5.0 EXCLUSIONS

5.1 Bone density studies for the routine screening of osteoporosis.

5.2 Ultrafast CT (electron beam CT (HCPCS code S8092)) to predict asymptomatic heart disease is preventive. Ultrafast CT (electron beam CT) is excluded for symptomatic patients and for screening asymptomatic patients for CAD.

5.3 MRIs (CPT⁵ procedure codes 77058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.

5.4 MRIs (CPT⁵ procedure codes 76058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.

5.5 3D rendering (CPT⁵ procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

5.6 3D rendering (CPT⁵ procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

5.7 3D rendering (CPT⁵ procedure codes 76376 and 76377) for use as a screening test for CAD in healthy individuals or in asymptomatic patients who have one or more traditional risk factors for CAD is unproven.

5.8 CT angiography for acute ischemic stroke is unproven.

5.9 CT angiography for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

5.10 CT, heart, without contrast material, with quantitative evaluation of coronary calcium (CPT⁵ procedure code 75571) is excluded for patients with typical anginal chest pain with high suspicion of CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

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5.11 CT, heart, without contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed) (CPT⁶ procedure code 75572) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

5.12 CT, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed) (CPT⁶ procedure code 75573) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

5.13 Computed tomographic angiography heart, coronary arteries and bypass (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) (CPT⁶ procedure code 75574) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

5.14 Multislice or multidetector row CT angiography of less than 16 slices per sec and 1 mm or less resolution is excluded.

5.15 Radiological supervision and interpretation of percutaneous vertebroplasty (CPT⁶ procedure codes 72291 and 72292).

5.16 Dual Energy X-Ray Absorptiometry (DXA) composition study (CPT⁶ procedure code 0028T) is unproven.

5.17 Computer-Aided Detection with breast MRI (CPT⁶ 0159T) is unproven.

5.18 Magnetic Resonance Spectroscopy (MRS), also known as NMR spectroscopy, of the brain is unproven.

6.0 EFFECTIVE DATES

6.1 The effective date for MRIs with contrast media is dependent on the U.S. Food and Drug Administration (FDA) approval of the contrast media and a determination by the contractor of whether the labeled or unlabeled use of the contrast media is medically necessary and a proven indication.

6.2 March 31, 2006, for breast MRI.

6.3 March 31, 2006, for coverage of multislice or multidetector row CT angiography.

6.4 January 1, 2007, for CPT⁶ procedure codes 72291 and 72292.

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6.5 January 1, 2007, for coverage of multislice of multidetector row CT angiography performed for presurgical evaluation prior to electrophysiological procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

6.6 October 1, 2008, for breast MRI for guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

6.7 October 3, 2006, for CMR.

6.8 December 9, 2014, for TE.

- END -

Nuclear Medicine

Issue Date: June 30, 1993

Authority: [32 CFR 199.4\(b\)\(2\)\(vii\)](#) and [\(c\)\(2\)\(ix\)](#)

1.0 CPT¹ PROCEDURE CODE RANGE

78012 - 79999

2.0 DESCRIPTION

Nuclear Medicine uses very small amounts of radioactive materials or radiopharmaceuticals to diagnose and treat disease. Radiopharmaceuticals are substances that are attracted to specific organs, bones, or tissues. The radiopharmaceutical used in nuclear medicine emit gamma rays that can be detected externally by gamma or Positron Emission Tomography (PET) cameras. These cameras work in conjunction with computers used to form images that provide data and information about the area of body being imaged. The following techniques are used in the diagnosis, management, treatment, and prevention of disease:

- Planar, Single Photon Emission Computed Tomography (SPECT);
- Positron Emission Tomography (PET);
- Tomography;
- Nuclear Medicine Scan;
- Radiopharmaceutical;
- Gamma Camera;
- In Vitro Fertilization (IVF) procedures done in test tubes - Radioimmunoassay (RIA) is a type of in vitro procedure; and
- In vivo procedures are when trace amounts of radiopharmaceuticals are given directly to a patient.

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3.0 POLICY

3.1 PET is covered for:

- 3.1.1 The diagnosis and management of seizure disorders.
- 3.1.2 Evaluation of ischemic heart disease.
- 3.1.3 The diagnosis, staging, restaging, and monitoring of treatment of pancreatic cancer.
- 3.1.4 PET and PET/CT for the staging and restaging of differentiated (follicular, papillary, Hürthle cell) thyroid cancer.
- 3.1.5 PET and PET/CT for ruling out recurrence of ovarian cancer.
- 3.1.6 PET and PET/CT for staging, restaging, and detection of recurrence of colorectal cancer.
- 3.1.7 PET/CT for metastatic bladder cancer.
- 3.1.8 Restaging of gastrointestinal stromal tumor (a rare disease).
- 3.1.9 The diagnosis and management of lung cancer when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).
- 3.1.10 PET and PET/CT for the diagnosis, staging, and monitoring of treatment of lymphoma.
- 3.1.11 PET and PET/CT for the initial diagnosis, staging, and monitoring of treatment of ovarian cancer.
- 3.1.12 In addition to the specific coverage indications listed in paragraphs 3.1.1 through 3.1.10, effective May 21, 2013, PET and PET/CT are proven diagnostics for the diagnosis, staging, restaging, and monitoring of oncologic indications, when supported by National Comprehensive Cancer Network (NCCN) clinical practice guidelines.

3.2 SPECT is covered for:

- 3.2.1 Myocardial perfusion imaging utilizing SPECT.
- 3.2.2 Brain imaging utilizing SPECT for the evaluation of seizure disorder.
- 3.2.3 Prostatic radioimmunoscintigraphy imaging utilizing SPECT for the following indications:
 - 3.2.3.1 Metastatic spread of prostate cancer and for use in post-prostatectomy patients in whom there is a high suspicion of undetected cancer recurrence.
 - 3.2.3.2 Newly diagnosed patients with biopsy-proven prostate cancer at high risk for spread of their disease to pelvic lymph nodes.

3.2.4 Indium¹¹¹ - for detecting the presence and location of myocardial injury in patients with suspected myocardial infarction.

3.2.5 Indium¹¹¹- labeled anti-TAG72 for tumor recurrence in colorectal and ovarian cancer.

3.2.6 SPECT for other indications is covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

3.3 Indium¹¹¹ Pentetreotide (Octreoscan) Scintigraphy is covered for:

3.3.1 The localization and monitoring of treatment of primary and metastatic neuroendocrine tumors.

3.3.2 Other indications when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

3.4 Bone Density Studies (CPT² procedure codes 78350 and 78351) are covered for:

3.4.1 The diagnosis and monitoring of osteoporosis.

3.4.2 The diagnosis and monitoring of osteopenia.

3.4.3 Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors for osteoporosis are those identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG).

4.0 EXCLUSIONS

4.1 Bone density studies for the routine screening of osteoporosis.

4.2 PET for the diagnosis and monitoring of treatment of Alzheimer's disease, fronto-temporal dementia or other forms of dementia is unproven.

4.3 PET and PET/CT are excluded for:

4.3.1 The initial diagnosis of differentiated thyroid cancer and for medullary cell thyroid cancer.

4.3.2 The diagnosis, staging, restaging, and monitoring of treatment of gastric cancer is unproven.

4.3.3 The initial diagnosis and monitoring of treatment of colorectal cancer is unproven.

4.3.4 The diagnosis of renal mass or possible Renal Cell Carcinoma (RCC) recurrence.

4.4 Ultrasound ablation (destruction of uterine fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT² procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

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4.5 Scintimammography (HCPCS code S8080), Breast-Specific Gamma Imaging (BSGI) (CPT² procedure codes 78800, 78801), and Molecular Breast Imaging (MBI) are unproven for all indications.

5.0 EFFECTIVE DATES

5.1 January 1, 1995, for PET for ischemic heart disease.

5.2 December 1, 1996, for PET for lung cancer.

5.3 October 14, 1990, for SPECT for myocardial perfusion imaging.

5.4 January 1, 1991, for SPECT for brain imaging.

5.5 October 28, 1996, for ¹¹¹In-Capromab Pendetide, CyT 356 (ProstaScint™).

5.6 June 1, 1994, for Octreoscan Scintigraphy.

5.7 May 26, 1994, for bone density studies.

5.8 January 1, 2006, for PET and PET/CT for pancreatic cancer.

5.9 February 16, 2006, for PET and PET/CT for thyroid cancer.

5.10 December 1, 2008, for PET and PET/CT for ruling out recurrence of ovarian cancer.

5.11 May 1, 2007, for PET and PET/CT for staging, restaging, and detection of recurrence of colorectal cancer.

5.12 January 1, 2010, for PET/CT for metastatic bladder cancer.

5.13 January 1, 2007, for PET and PET/CT for lymphoma.

5.14 January 1, 2010, for PET for gastrointestinal stromal tumor (a rare disease).

5.15 May 21, 2013, for PET and PET/CT are proven diagnostics for the diagnosis, staging, restaging and monitoring of oncologic indications when supported by NCCN clinical practice guidelines.

5.16 February 1, 2015, PET and PET/CT are proven for the initial diagnosis, staging, and monitoring of treatment of ovarian cancer.

- END -

Ophthalmological Services

Issue Date: November 3, 1992

Authority: [32 CFR 199.4\(c\)\(2\)\(xvi\)](#), [\(e\)\(6\)](#), [\(g\)\(46\)](#), [\(g\)\(50\)](#), and 10 USC 1079(a)(3)

1.0 CPT¹ PROCEDURE CODE RANGES

92002 - 92060, 92070 - 92335, 92390 - 92499

2.0 DESCRIPTION

Ophthalmological services may include an examination and other specialized services. The purpose of an examination is to diagnose or treat a medical condition of the eye, eyelid, lacrimal system, or orbit. A "routine eye examination" is an evaluation of the eyes, including but not limited to refractive services, that is not related to a medical or surgical condition or to the medical or surgical treatment of a covered illness or injury.

3.0 POLICY

3.1 For all beneficiaries, ophthalmological services (including refractive services) provided in connection with the medical or surgical treatment of a covered illness or injury are covered.

3.2 For Active Duty Family Members (ADFM)s payment can be made for one routine eye examination per year.

3.2.1 Routine eye examinations as defined in [32 CFR 199.2](#) includes coverage of those services rendered in order to determine the refractive state of the eyes. The CPT¹ procedure codes for payment of routine eye examinations are as follows:

92002 - EYE EXAM, NEW PATIENT
92004 - EYE EXAM, NEW PATIENT
92012 - EYE EXAM, ESTABLISHED PATIENT
92014 - EYE EXAM & TREATMENT
92015 - REFRACTION
99172 - OCULAR FUNCTION SCREEN
99173 - VISUAL ACUITY SCREEN

3.2.2 TRICARE Prime and Standard ADFMs are entitled to one annual routine eye. Prime ADFMs may receive their annual routine eye examination from any network provider without referral, authorization, or preauthorization from the Primary Care Manager (PCM), or any other authority; i.e., a Prime ADFM will be allowed to set up his or her own appointment for a routine eye

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examination with any network optometrist or ophthalmologist. Standard ADFMs may self-refer to any TRICARE authorized provider regardless of whether or not they are a network provider; i.e., a Standard ADFM may set up his or her own appointment with either a network or non-network, TRICARE authorized, optometrist or ophthalmologist.

3.3 For Prime enrollees, see [Section 2.2](#) for additional information on routine eye examinations.

3.4 Heidelberg Retina Tomograph (HRT), and Scanning laser polarimetry (GDx) (CPT² procedure code 92135) to diagnose and monitor progression of suspected glaucoma may be considered for cost-sharing. Optical Coherence Tomograph (OCT) to diagnose and monitor progression of suspected retinal disease may be considered for cost-sharing. Effective October 28, 2008.

4.0 EXCLUSIONS

4.1 Routine eye examinations are NOT covered for Standard retirees or their dependents that are not enrolled in Prime except for eye exams allowed under the well-child benefit in [Section 2.5](#).

4.2 Orthoptics, also known as vision training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT² procedure code 92065).

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Neurology And Neuromuscular Services

Issue Date: April 19, 1983

Authority: [32 CFR 199.4\(b\)\(2\)\(vii\)](#) and [\(b\)\(3\)\(v\)](#)

1.0 CPT¹ PROCEDURE CODES

20552, 20553, 95812 - 95999

2.0 HCPCS PROCEDURE CODE

J9310

3.0 DESCRIPTION

The diagnosis and treatment of muscle and nerve disorders.

4.0 POLICY

4.1 Neurology and neuromuscular services are covered.

4.2 The Epley Canalith Repositioning Procedure (CRP) is covered for the treatment of Benign Paroxysmal Positional Vertigo (BPPV) with an effective date of June 13, 2012.

4.3 Off-label use of rituximab may be considered for cost-sharing for the treatment of Chronic Inflammatory Demyelinating Polyneuropathy (CIDP). The effective date is July 16, 2010.

4.4 Off-label use of rituximab injections may be considered for cost-sharing for the treatment of Stiff Person Syndrome. The effective date is March 31, 2005.

5.0 EXCLUSIONS

5.1 Topographic brain mapping (HCPCS S8040) is unproven.

5.2 Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy, are unproven.

- END -

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