



DEFENSE  
HEALTH AGENCY

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**CHANGE 174  
6010.57-M  
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The Defense Health Agency has authorized the following addition(s)/revision(s).

**CHANGE TITLE: EVOLVING PRACTICES 16-005**

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**PAGE CHANGE(S): See page 2.**

**SUMMARY OF CHANGE(S): See page 3.**

**EFFECTIVE DATE: See page 3.**

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**CHANGE 174  
6010.57-M  
NOVEMBER 3, 2016**

**REMOVE PAGE(S)**

**CHAPTER 4**

Section 13.1, page 3

Section 14.1, pages 1 and 2

Section 19.1, page 1

Section 21.1, pages 1 and 2

**CHAPTER 5**

Section 1.1, pages 3, 4, 7, and 8

**INSERT PAGE(S)**

Section 13.1, page 3

Section 14.1, pages 1 and 2

Section 19.1, page 1

Section 21.1, pages 1 through 3

Section 1.1, pages 3, 4, 7, and 8

## **SUMMARY OF CHANGES**

### **CHAPTER 4**

1. Section 13.1. This change excludes LINX™ Reflux Management System for the treatment of gastroesophageal reflux disease. EFFECTIVE DATE: 08/16/2016.
2. Section 14.1. This change adds coverage of prostatic urethral lift for the treatment of urinary outflow obstruction secondary to benign prostatic hyperplasia. EFFECTIVE DATE: 09/16/2015.
3. Section 19.1. This change adds coverage for the Off-label use of Sandostatin LAR/octreotide for the treatment of autosomal dominant polycystic kidney disease. EFFECTIVE DATE: 08/31/2015.
4. Section 21.1. This change adds coverage for iStent® Trabecular Micro-Bypass Stent System for the treatment of primary open angle glaucoma and cataracts. EFFECTIVE DATE: 10/07/2015.

### **CHAPTER 5**

5. Section 1.1.
  - a. This change excludes maternity ultrasound from three-dimensional (3D) rendering (CPT procedure codes 76376 and 76377) being medically necessary under certain circumstances. EFFECTIVE DATE: 09/13/2016.
  - b. This change excludes digital breast tomosynthesis (DBT) for the diagnosis of breast cancer. EFFECTIVE DATE: 09/13/2016.



**4.4** RFA for treatment of liver metastases from primary sites other than colorectal metastases is unproven (CPT<sup>3</sup> 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.

**4.6** Magnetic sphincter augmentation with the LINX™ Reflux Management System for the treatment of GERD is unproven.

## **5.0 EFFECTIVE DATES**

**5.1** RFA (CPT<sup>3</sup> 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 (CPT<sup>3</sup> 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 (CPT<sup>3</sup> procedure code 0184T) for treatment of benign lesions or malignant T1 tumors is covered effective June 2, 2009.

**5.4** THD (CPT<sup>3</sup> procedure code 0249T) is covered effective October 28, 2013.

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## Urinary System

Issue Date: August 26, 1985

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

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

50010 - 53899, 64561, 64581, 64585, 64590, 64595

### 2.0 DESCRIPTION

The urinary system involves those organs concerned in the production and excretion of urine.

### 3.0 POLICY

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

**3.2** Benefits may be considered for the implantation of similar U.S. Food and Drug Administration (FDA) approved devices. The Sacral Nerve Root Stimulation (SNS) has received FDA approval. Services and supplies related to the implantation of the SNS may be covered for individuals with urge incontinence, nonobstructive urinary retention, or symptoms of urgency-frequency syndrome that is not due to a neurologic condition, who have failed previous conservative treatments, and who have had a successful peripheral nerve evaluation test.

**3.3** The use of a bedwetting alarm for the treatment of primary nocturnal enuresis may be considered for cost-sharing when prescribed by a physician and after physical or organic causes for nocturnal enuresis have been ruled out.

**3.4** Collagen implantation of the urethra and/or bladder neck may be covered for patients not amenable to other forms of urinary incontinence treatment.

**3.5** Cryoablation for renal cell carcinoma (CPT<sup>1</sup> procedure codes 50250 and 50593) may be considered for coverage under the Rare Disease policy ([Chapter 1, Section 3.1](#)) on a case-by-case basis. Effective June 1, 2006.

**3.6** Under the provisions for the treatment of rare diseases, coverage of laparoscopic Radiofrequency Ablation (RFA) (CPT<sup>1</sup> procedure code 50542) and Percutaneous Radiofrequency Ablation (PRFA) (CPT<sup>1</sup> procedure code 50592) may be considered on a case-by-case basis for the treatment of Renal Cell Carcinoma (RCC) and genetic syndromes associated with RCC including von

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Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma for patients who are not appropriate candidates for surgical intervention.

**3.7** Posterior Tibial Nerve Stimulation (PTNS) for treatment of overactive bladder, to include urinary frequency, urge, and incontinence (CPT<sup>2</sup> procedure code 64566) is proven.

**3.8** Prostatic Urethral Lift (PUL) for the treatment of urinary outflow obstruction secondary to Benign Prostatic Hyperplasia (BPH) (CPT<sup>2</sup> procedure codes 52441, 52442; HPCPCS cods C9739, C9740) is proven.

#### **4.0 EXCLUSIONS**

**4.1** Peri-urethral Teflon injection is unproven.

**4.2** Silastic gel implant.

**4.3** Acrylic prosthesis (Berry prosthesis).

**4.4** Bladder stimulators, direct or indirect, such as spinal cord, rectal and vaginal electrical stimulators, or bladder wall stimulators. Payment for any related service or supply, including inpatient hospitalization primarily for surgical implementation of a bladder stimulator.

**4.5** Transurethral balloon dilation of the prostate (CPT<sup>2</sup> procedure code 52510) is unproven.

**4.6** Cryoablation for the treatment of renal angiomyolipoma is unproven.

#### **5.0 EFFECTIVE DATE**

**5.1** Transurethral Needle Ablation (TUNA) of the prostate is proven (CPT<sup>2</sup> procedure code 53852). Effective June 1, 2004.

**5.2** March 28, 2007, for laparoscopic RFA or PRFA for the treatment of RCC and genetic syndromes associated with RCC, including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma.

**5.3** December 9, 2014, for PTNS for the treatment of overactive bladder.

**5.4** September 16, 2015, for PUL for the treatment of urinary outflow obstruction secondary to BPH.

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## Endocrine System

Issue Date: August 26, 1985

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

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

60000 - 60699

### 2.0 DESCRIPTION

**2.1** The endocrine system consists of glands and other structures that elaborate internal secretions (hormones) which are released directly into the circulatory system and which influence metabolism and other body processes.

**2.2** Organs having endocrine function include the pituitary, thyroid, parathyroid, and adrenal glands, the pineal body, the gonads, the pancreas, and the paraganglia.

### 3.0 POLICY

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

**3.2** Effective August 31, 2015, off-label use of Sandostatin LAR/octreotide in the treatment of autosomal dominant polycystic kidney disease is covered.

### 4.0 EXCLUSION

Carotid body resection (CPT<sup>1</sup> procedure codes 60600 and 60605) when done solely to relieve the symptoms of pulmonary dyspnea, including chronic obstructive pulmonary disease, is unproven.

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## Eye And Ocular Adnexa

Issue Date: August 26, 1985

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

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

0191T, 0192T, 0253T, 0308T, 0376T, 65091 - 65755, 65772 - 66175, 66180 - 68899, 77600 - 77615

### 2.0 HCPCS PROCEDURE CODES

C1783, L8612

### 3.0 DESCRIPTION

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

### 4.0 POLICY

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

**4.2** Phototherapeutic Keratectomy (PTK) is covered for corneal dystrophies.

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

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

**4.5** Transpupillary thermotherapy (laser hyperthermia, CPT<sup>1</sup> procedure codes 77600 - 77615), with chemotherapy, is covered for the treatment of retinoblastoma. See also [Chapter 5, Section 5.1](#).

**4.6** 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.

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**4.7** Optonal ExPRESS Mini glaucoma Shunt (CPT<sup>2</sup> procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.

**4.8** Off-label use of Photodynamic Therapy (CPT<sup>2</sup> 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.

**4.9** Transpupillary thermotherapy (CPT<sup>2</sup> procedure code 67299) with Plaque Radiotherapy (Brachytherapy) is covered for the treatment of choroidal melanoma. See also [Chapter 5, Section 3.2](#).

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

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

**4.12** Canaloplasty for the treatment of primary open angle glaucoma (CPT<sup>2</sup> procedure codes 66174 and 66175) is covered.

**4.13** Insertion of anterior segment aqueous drainage device (iStent<sup>®</sup>), without extra ocular reservoir, internal approach, during cataract surgery to reduce IOP in the treatment of glaucoma, initial insertion (CPT<sup>2</sup> procedure codes 0191T, 0253T, C1783, and L8612), and each additional insertion (CPT<sup>2</sup> procedure code 0376T).

## **5.0 EXCLUSIONS**

**5.1** Refractive corneal surgery except as noted in [paragraph 4.4](#) (CPT<sup>2</sup> procedure codes 65760, 65765, 65767, 65770, 65771).

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

**5.3** Orthokeratology.

**5.4** Orthoptics, also known as visual training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT<sup>2</sup> procedure code 92065).

**5.5** Epikeratophakia for treatment of aphakia and myopia is unproven.

**5.6** Transpupillary thermotherapy (CPT<sup>2</sup> procedure code 67299) as primary treatment of choroidal melanoma is unproven.

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

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**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 4, Section 21.1

Eye And Ocular Adnexa

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**6.0 EFFECTIVE DATES**

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

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

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

**6.4** June 17, 2015, coverage date for IMT.

**6.5** October 7, 2015, coverage date for iStent®.

- END -



**4.4.2** Detection of CAD:

- Symptomatic--evaluation of intracardiac structures (use of Magnetic Resonance (MR) coronary angiography).
- Evaluation of suspected coronary anomalies.

**4.4.3** Risk assessment with prior test results (use of vasolidator perfusion CMR or dobutamine stress function CMR).

- Coronary angiography (catheterization or CT).
- Stenosis of unclear significance.

**4.4.4** Structure and Function. Evaluation of ventricular and valvular function. Procedures may include Left Ventricular (LV)/Right Ventricular (RV) mass and volumes, MRA, quantification of valvular disease, and delayed contrast enhancement.

**4.4.4.1** Assessment of complex congenital heart disease including anomalies of coronary circulation, great vessels, and cardiac chambers and valves.

**4.4.4.2** Evaluation of LV function following Myocardial Infarction (MI) OR in heart failure patients. Patients with technically limited images from echocardiogram.

**4.4.4.3** Quantification of LV function. Discordant information that is clinically significant from prior tests.

**4.4.4.4** Evaluation of specific cardiomyopathies (infiltrative [amyloid, sarcoid], Hypertrophic Cardiomyopathy (HCM), or due to cardiotoxic therapies.

**4.4.4.5** Characterization of native and prosthetic cardiac valves--including planimetry of stenotic disease and quantification of regurgitant disease. Patients with technically limited images from echocardiogram or Transesophageal Echocardiography (TEE).

**4.4.4.6** Evaluation for Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC). Patients presenting with syncope or ventricular arrhythmia.

**4.4.4.7** Evaluation of myocarditis or MI with normal coronary arteries. Positive cardiac enzymes without obstructive atherosclerosis on angiography.

**4.4.5** Structure and Function. Evaluation of intracardiac and extracardiac structures.

**4.4.5.1** Evaluation of cardiac mass (suspected tumor or thrombus). Use of contrast for perfusion and enhancement.

**4.4.5.2** Evaluation of pericardial conditions (pericardial mass, constrictive pericarditis).

**4.4.5.3** Evaluation for aortic dissection.

**4.4.5.4** Evaluation of pulmonary veins prior to radiofrequency ablation for atrial fibrillation. Left atrial and pulmonary venous anatomy including dimensions of veins for mapping purposes.

**4.4.6** Detection of Myocardial Scar and Viability. Evaluation of myocardial scar (use of late gadolinium enhancement).

**4.4.6.1** To determine the location and extent of myocardial necrosis including “no reflow” regions. Post acute MI.

**4.4.6.2** To determine viability prior to revascularization. Establish likelihood of recovery of function with revascularization (Percutaneous Coronary Intervention [PCI] or Coronary Artery Bypass Graft [CABG]) or medical therapy.

**4.4.6.3** To determine viability prior to revascularization. Viability assessment by Single Photon Emission Tomography (SPECT) or dobutamine echo has provided “equivocal or indeterminate” results.

**4.5** MRA is covered when medically necessary, appropriate and the standard of care. (CPT<sup>3</sup> procedure codes 70544 - 70549, 71555, 72159, 72198, 73225, 73725, and 74185.)

**4.6** CT scans are covered when medically necessary, appropriate and the standard of care and all criteria stipulated in [32 CFR 199.4\(e\)](#) are met. (CPT<sup>3</sup> procedure codes 70450 - 70498, 71250 - 71275, 72125 - 72133, 72191 - 72194, 73200 - 73206, 73700 - 73706, 74150 - 74175, 75635, and 76355 - 76380.)

**4.7** TRICARE considers three-dimensional (3D) rendering (CPT<sup>3</sup> procedure codes 76376 and 76377) medically necessary under certain circumstances (see [Section 2.1](#), for exclusion with **maternity ultrasound**).

**4.8** Helical (spiral) CT scans, with or without contrast enhancement, are covered when medically necessary, appropriate and the standard of care.

**4.9** Chest x-rays (CPT<sup>3</sup> procedure codes 71010 - 71035) are covered.

**4.10** Diagnostic mammography (CPT<sup>3</sup> procedure codes 76090 - 76092/HCPCS codes G0204 - G0207) to further define breast abnormalities or other problems is covered.

**4.11** Portable X-ray services are covered. The suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations, or the Medicaid program in that state in which the covered service is provided. In addition to the specific radiology services, reasonable transportation and set-up charges are covered and separately reimbursable.

**4.12** Bone density studies (CPT<sup>3</sup> procedure codes 77078 - 77082) are covered for the following:

**4.12.1** The diagnosis and monitoring of osteoporosis.

**4.12.2** The diagnosis and monitoring of osteopenia.

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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) (CPT<sup>6</sup> 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) (CPT<sup>6</sup> 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) (CPT<sup>6</sup> 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 (CPT<sup>6</sup> procedure codes 72291 and 72292).

**5.16** Dual Energy X-Ray Absorptiometry (DXA) composition study (CPT<sup>6</sup> procedure code 0028T) is unproven.

**5.17** Computer-Aided Detection with breast MRI (CPT<sup>6</sup> 0159T) is unproven.

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

**5.19** Digital Breast Tomosynthesis (DBT) (CPT<sup>6</sup> procedure codes 77061 and 77062) 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 CPT<sup>6</sup> procedure codes 72291 and 72292.

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**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 5, Section 1.1

Diagnostic Radiology (Diagnostic Imaging)

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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.

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