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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 29
6010.57-M
JULY 15, 2010**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: EVOLVING PRACTICES - JANUARY 2010

CONREQ: 14937

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See pages 3 and 4.

EFFECTIVE AND IMPLEMENTATION DATE: As indicated, otherwise upon direction of the Contracting Officer.


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Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 74 PAGE(S)
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CHANGE 29
6010.57-M
JULY 15, 2010

REMOVE PAGE(S)

CHAPTER 4

Section 6.1, pages 1 and 2
Section 15.1, page 3
Section 23.1, pages 5, 6, 9, 10

CHAPTER 5

Section 1.1, pages 1 - 7
Section 4.1, page 3

CHAPTER 7

Section 2.1, pages 1, 2, 5 - 11
Section 2.2, pages 1 - 6
Section 3.10, pages 1 - 3
Section 6.1, pages 1 and 2
Section 15.1, page 1
Section 18.2, pages 1 - 3
Section 27.1, pages 1 and 2

APPENDIX A

pages 1 - 29

INSERT PAGE(S)

Section 6.1, pages 1 and 2
Section 15.1, page 3
Section 23.1, pages 5, 6, 9, 10

Section 1.1, pages 1 - 8
Section 4.1, pages 3 and 4

Section 2.1, pages 1, 2, 5 - 11
Section 2.2, pages 1 - 8
Section 3.10, pages 1 - 3
Section 6.1, pages 1 and 2
Section 15.1, page 1
Section 18.2, pages 1 - 3
Section 27.1, pages 1 and 2

pages 1 - 29

SUMMARY OF CHANGES

CHAPTER 4

1. Section 6.1. Lumbar total disc arthroplasty for degenerative disc disease is unproven. Revised Exclusions to include the appropriate CPT codes. Typographical error correction.
2. Section 15.1. Added prostate saturation biopsy to the Exclusions list.
3. Section 23.1. Added coverage of Donor Lymphocyte Infusion (DHI) for treatment of patients with Acute Myelogenous/Myeloid Leukemia (AML) who relapse following allogenic stem cell transplantation.

CHAPTER 5

4. Section 1.1. Added covered indications for Cardiovascular Magnetic Resonance (CMR); removed CPT procedure codes 0144T-0151T and added CPT codes 75571-75574. Revised and clarified the Exclusions paragraphs.
5. Section 4.1. Added as Exclusions: Scintimammography Breast-Specific Gamma Imaging (BSGI) and Molecular Breast Imaging (MBI) are unproven.

CHAPTER 7

6. Section 2.1. Clarified colorectal cancer risk factors and screening coverage to reflect the most current recommended guidelines of the American Cancer Society (ACS). Clarified coverage of vaccines recommended for travel outside the United States. Addressed some editorial clarifications.
7. Section 2.2. Clarified frequency or age intervals for clinical preventive services for TRICARE prime.
8. Section 3.10. Revised the policy to exclude the use of Microcurrent Electrical Therapy (MET) and Cranial Electrotherapy Stimulation (CES) for the treatment of anxiety, depression and insomnia, and electrical stimulation devices used to apply these therapies.
9. Section 6.1. Revised policy to allow Optical Coherence Tomograph (OCT) to diagnose and monitor suspected retinal disease, rather than for glaucoma only.
10. Section 15.1. Revised the policy to exclude the use of Microcurrent Electrical Therapy (MET) and Cranial Electrotherapy Stimulation (CES) for the treatment of anxiety, depression and insomnia, and electrical stimulation devices used to apply these therapies.

CHANGE 29
6010.57-M
JULY 15, 2010

SUMMARY OF CHANGES (Continued)

CHAPTER 7 (Continued)

11. Section 18.2. Revised the policy to exclude the use of mechanical or motorized traction to provide nonsurgical spinal decompression therapy.
12. Section 27.1. Revised the policy to allow botulinum toxin A injections for the treatment of spasticity due to Cerebral Palsy (CP), including treatment in pediatric patients.

APPENDIX A

13. Added new acronyms and corrected typographical error.