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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 31
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The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: EVOLVING PRACTICES - MARCH 2010

CONREQ: 15014

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): 28 PAGE(S)
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CHANGE 31
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Section 12.1, pages 1 and 2

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 3.1. Intracranial angioplasty with stenting of the venous sinuses for treatment of pseudotumor cerebri is unproven and added as an exclusion.
2. Section 12.1. Computer-Aided Detection (CAD) with breast MRI is unproven and added as an exclusion.

CHAPTER 4

3. Section 6.1. Femoroplasty for the treatment of Femoroacetabular Impingement (FAI) syndrome is unproven and added as an exclusion. Osteochondral allograft of the humeral head with meniscal transplant and glenoid microfracture in the treatment of shoulder pain and instability is unproven and added as an exclusion.
4. Section 9.1. Intracranial angioplasty with stenting of the venous sinuses for treatment of pseudotumor cerebri is unproven and added as an exclusion.
5. Section 20.1. Editorial corrections.
6. Section 24.1. Removed age greater than or equal to 65 years from the list of contraindications for heart-lung and lung transplantation.

CHAPTER 5

7. Section 1.1. Computer-Aided Detection (CAD) with breast MRI is unproven and added as an exclusion.

CHAPTER 7

8. Table of Contents. Removed "Excludes Chemotherapy" the title of Section 2.8.
9. Section 2.8. Removed "Excludes Chemotherapy" from the title. Allows for off-label use of zoledronic acid (Zometa) for treatment of breast cancer.
10. Section 16.3. Adds covered indications for paclitaxel (Taxol) and paclitaxel protein-bound particles (Abraxane) for the treatment of breast cancer.

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SUMMARY OF CHANGES (Continued)

CHAPTER 8

11. Section 16.1. Intrapulmonary Percussive Ventilation (IPV) for the treatment of Cystic Fibrosis (CF) is unproven and added as an exclusion.

Chapter 1

Section 3.1

Rare Diseases

Issue Date: May 18, 1994

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

1.0 DESCRIPTION

TRICARE defines a rare disease as any disease or condition that affects less than 200,000 persons in the United States.

2.0 POLICY

2.1 Coverage for treatment of rare diseases may be considered on a case-by-case basis. Case-by-case review is not required for drugs, devices, medical treatments, and procedures that have already been established as safe and effective for treatment of rare diseases.

2.1.1 In reviewing the case, any or all of the following sources may be used to determine if the proposed benefit is considered safe and effective.

2.1.2 Trials published in refereed medical literature.

2.1.3 Formal technology assessments.

2.1.4 National medical policy organization positions.

2.1.5 National professional associations.

2.1.6 National expert opinion organizations.

2.2 If case review indicates that the proposed benefit for a rare disease is safe and effective for that disease, benefits may be allowed. If benefits are denied, an appropriate appealing party may request an appeal.

2.3 Off-label use of rituximab may be considered for cost-sharing for the treatment of recurrent nodular CD20 positive lymphocyte predominant Hodgkin's disease. The effective date is January 1, 2003.

2.4 Off-label use of rituximab may be considered for cost-sharing in reducing proteinuria for the treatment of Immunoglobulin A (IgA) nephropathy (proliferative glomerulonephritis). The effective date is May 1, 2007.

2.5 Effective May 13, 2009, Intraperitoneal Hyperthermic Chemotherapy (IPHC) (Current Procedural Terminology (CPT)¹ procedure codes 77600, 77605, and 96445) in conjunction with cytoreductive surgery or peritonectomy for treatment of pseudomyxoma peritonei resulting from appendiceal carcinoma may be covered 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 has not undergone preoperative systemic chemotherapy.
- The patient's condition does not preclude major surgery.
- The chemotherapeutic agents used are Mitomycin C, Cisplatin (also known as Cisplatinum), or Fluorouracil.

3.0 EXCLUSION

Intracranial angioplasty with stenting (CPT¹ procedure code 61635) of the venous sinuses for treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension) is unproven.

- END -

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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

0003T, 0008T, 0016T - 0019T, 0021T, 0024T, 0026T - 0032T, 0041T - 0161T

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 Category III code 0024T may be covered under the Rare Disease Policy for children.

4.2 FDA IDE (Category B) clinical trial. See [Chapter 8, Section 5.1](#).

4.3 Category III codes 0145T - 0151T as outlined in [Chapter 5, Section 1.1](#).

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

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

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5.0 EXCLUSION

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.

- 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

20000 - 22505, 22520 - 22525, 22532 - 22534, 22548 - 28825, 28899 - 29863, 29866, 29867, 29870 - 29999

2.0 HCPCS CODES

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 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes 22523-22525) 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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5.0 EXCLUSIONS

- 5.1** Percutaneous vertebroplasty (CPT² procedure codes 22520 - 22525) is unproven.
- 5.2** Percutaneous kyphoplasty (CPT² procedure codes 22523 - 22525) for the treatment of vertebral fractures is unproven.
- 5.3** Meniscal transplant (CPT² procedure code 29868) for meniscal injury is unproven.
- 5.4** Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.
- 5.5** Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.
- 5.6** Trigger point injection (CPT² procedure codes 20552 and 20553) for migraine headaches.
- 5.7** IDET (Intradiscal Electrothermal Therapy) for Chronic Discogenic Pain (CPT² procedure codes 0062T and 0063T) is unproven.
- 5.8** Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT² procedure code 22856) each additional interspace (CPT² procedure code 0092T) is unproven.
- 5.9** Removal of total disc arthroplasty anterior approach cervical; single interspace (CPT² procedure code 22864) each additional interspace (CPT² procedure code 0095T) is unproven. Also, see [Section 1.1](#).
- 5.10** Lumbar total disc arthroplasty (lumbar artificial intervertebral disc revision including replacement, lumbar total disc replacement) for degenerative disc disease is unproven (CPT² procedure codes 22857, 22562, 0163T, 0164T, and 0165T).
- 5.11** Extracorporeal Shock Wave Therapy (ESWT) for the treatment of plant fasciitis or lateral epicondylitis is unproven.
- 5.12** XSTOP Interspinous Process Decompression System for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.
- 5.13** Hip core decompression is unproven.
- 5.14** Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT² procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.
- 5.15** Hip arthroscopy (CPT² procedure code 29862) for the treatment of FAI and debridement of articular cartilage is unproven.
- 5.16** Femoroplasty (CPT² procedure code 29999) for the treatment of FAI syndrome is unproven.

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Chapter 4, Section 6.1

Musculoskeletal System

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

6.0 EFFECTIVE DATE

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

6.2 May 1, 2008, for TAR.

- END -

3.11.7 All procedures are performed in a Centers for Medicare and Medicaid Services (CMS) approved facility that has been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes.

4.0 EXCLUSIONS

4.1 Thermogram; cephalic (CPT⁴ procedure code 93760); peripheral (CPT⁴ procedure code 93762) are unproven.

4.2 Percutaneous Myocardial Laser Revascularization (PMR) is unproven.

4.3 Cardiomyoplasty (Cardiac Wrap) for treatment of heart failure is unproven.

4.4 Minimally Invasive CABG surgery to include Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) and Port Access Coronary Artery Bypass (PACAB) are unproven.

4.5 Percutaneous Transluminal Angioplasty (PTA) in the treatment of obstructive lesions of the vertebral and cerebral arteries is unproven. PTA of the carotid artery without stenting is unproven. PTA of the carotid artery with stenting but without embolic protection (CPT⁴ procedure code 37216) is unproven.

4.6 Signal-Average Electrocardiography (CPT⁴ procedure code 93278) is unproven.

4.7 Percutaneous transluminal mechanical thrombectomy vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance (CPT⁴ procedure code 37187) is unproven.

4.8 Percutaneous transluminal mechanical thrombectomy, vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy (CPT⁴ procedure code 37188) is unproven.

4.9 Intracranial angioplasty with stenting (CPT⁴ procedure code 61635) of the venous sinuses for treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension) is unproven.

5.0 EFFECTIVE DATES

5.1 March 1, 2001, for gamma and beta intracoronary radiotherapy (brachytherapy).

5.2 January 1, 2002, for TMR.

5.3 October 1, 2003, for VADs as destination therapy.

5.4 December 1, 2003, for endovenous radiofrequency ablation/obliteration.

5.5 January 1, 2005, for ABPM.

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Chapter 4, Section 9.1

Cardiovascular System

5.6 March 17, 2005, for PTA of the carotid artery with stenting in beneficiaries at high risk for CEA.

5.7 March 21, 2006, for percutaneous transluminal mechanical thrombectomy for acute limb ischemia.

5.8 January 1, 2007, for pulmonary vein isolation/ablation.

- END -

3.13 Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT³ procedure codes 63050 and 63051).

3.14 Balloon angioplasty, intracranial, percutaneous (CPT³ procedure code 61630) is unproven.

3.15 Transcatheter placement of intravascular stent(s) intracranial (e.g., atherosclerotic or venous sinus stenosis) including angioplasty, if performed (CPT³ procedure code 61635) is unproven.

3.16 Balloon dilation of intracranial vasospasm, initial vessel (CPT³ procedure code 61640) each additional vessel in same family (CPT³ procedure code 61641) or different vascular family (CPT³ procedure code 61642) is unproven.

3.17 Endoscopic thoracic sympathectomy.

3.18 Trigger point injection for migraine headaches.

3.19 Botox (chemodenervation), surgical denervation, and muscle resection for migraine headaches are unproven.

3.20 Sphenopalatine ganglion block (CPT³ procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

3.21 Radiofrequency ablation (percutaneous radiofrequency facet denervation, percutaneous facet coagulation, percutaneous radiofrequency neurotomy, radiofrequency facet rhizotomy, radiofrequency articular rhizolysis) (CPT³ procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic spinal pain is unproven. Pulsed radiofrequency ablation for spinal pain is unproven.

3.22 Implantation of Occipital Nerve Stimulator for the treatment of chronic intractable migraine headache is unproven.

3.23 Cryoablation of Occipital Nerve (CPT³ procedure code 64640) for the treatment of chronic intractable headache is unproven.

3.24 Spinal cord and deep brain neurostimulation in the treatment of chronic intractable headache or migraine pain is unproven.

4.0 EFFECTIVE DATES

4.1 January 1, 1989, for PAVM.

4.2 April 1, 1994, for therapeutic embolization for treatment of meningioma.

4.3 July 14, 1997, for GDC.

4.4 The date of FDA approval of the embolization device for all other embolization procedures.

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Chapter 4, Section 20.1

Nervous System

4.5 June 1, 2004, for Magnetoencephalography.

- END -

3.6.7 Cachexia, even in the absence of major end organ failure (because of the significantly less favorable survival of these patients).

3.6.8 Obesity, with weight being an increasingly severe adverse factor as the patient exceeds by 20% of ideal weight for height and sex (because of more difficult post-operative mobilization and impaired diaphragmatic function, as well as the difficulty of weight control once corticosteroid immunosuppressant is instituted).

3.6.9 A history of a behavior pattern or psychiatric illness considered likely to interfere significantly with compliance with a disciplined medical regimen (because a lifelong medical regimen is necessary requiring multiple drugs several times a day, with serious consequences in the event of their interruption of excessible consumption).

3.6.10 Active cigarette smoking (abstinence of a minimum of four months prior to transplantation is recommended).

3.6.11 Previous thoracic or cardiac surgery or other bases for pleural adhesions may be a serious adverse factor depending upon site of thoracotomy/sternotomy, the degree of adhesions and the type of transplant anticipated (because of scar tissue and the propensity for inadequately controlled bleeding).

3.6.12 Recent or current history of gastrointestinal problems (because of common post-operative gastrointestinal problems and hemorrhage).

3.6.13 Chronic corticosteroid therapy that cannot be tapered and discontinued prior to transplantation has been considered a serious adverse factor by many (because of the increased risk of tracheal or bronchial dehiscence in the early post-operative period).

3.6.14 With chronic pulmonary infection (as with bronchiectasis, chronic or cystic fibrosis), single lung transplantation is contraindicated (because of the great likelihood of the infection extending from the contaminated native lung into the transplanted lung) and the patient must meet the criteria and benefit/risk considerations of double lung or heart-lung transplantation.

3.6.15 With significant heart disease (for example, substantial irreversible right ventricular disease or significant coronary artery disease) the patient must meet the criteria and benefit/risk considerations for heart-lung transplantation; lung transplantation and concurrent repair of the cardiac abnormality may be appropriate in unusual circumstances, as in some situations with Eisenmenger's syndrome.

3.6.16 Primary or metastatic malignancies of the lung.

3.7 Services and supplies related to heart-lung or lung transplantation are covered for:

3.7.1 Evaluation of potential candidate's suitability for heart-lung or lung transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation.

3.7.2 Pre- and post-transplant inpatient hospital and outpatient services.

3.7.3 Pre- and post-operative services of the transplant team.

- 3.7.4** The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.
- 3.7.5** The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.
- 3.7.6** Donor costs.
- 3.7.7** Blood and blood products.
- 3.7.8** U.S. Food and Drug Administration (FDA) approved immunosuppression drugs to include off-label uses when reliable evidence documents that the off-label use is safe, effective and in accordance with nationally accepted standards of practice in the medical community (proven).
- 3.7.9** Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.
- 3.7.10** Periodic evaluation and assessment of the successfully transplanted patient.
- 3.7.11** Cardiac rehabilitation.
- 3.7.12** Pulmonary rehabilitation for pre- and post-lung and heart-lung transplants
- 3.7.13** Transportation of the patient by air ambulance and the services of a certified life support attendant.
- 3.7.14** Deoxyribonucleic Acid-Human Leucocyte Antigen (DNA-HLA) tissue typing in determining histocompatibility.
- 3.8** TRICARE may cost-share for epoprostenol (FLOLAN®) for the management of severe secondary pulmonary hypertension, including those for patients with pulmonary hypertension secondary to the scleroderma spectrum of diseases, whether or not they have been authorized for and are awaiting lung transplantation.

4.0 POLICY CONSIDERATION

4.1 In those cases where the beneficiary fails to obtain preauthorization, benefits may be extended if the services of supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the heart-lung or lung transplantation benefit. Charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under POS rules.

4.2 Benefits will only be allowed for transplants performed at a TRICARE or Medicare-certified heart, heart-lung or lung transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a heart, heart-lung, or lung transplantation center on the basis that the center belongs to a pediatric consortium program

whose combined experience and survival data meet the TRICARE criteria for certification. The contractor is the certifying authority for transplant centers within its region. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

4.3 Heart-lung, and lung transplantation will be paid under the DRG.

4.4 Claims for transportation of the donor organ and transplant team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

4.5 Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplant center in the name of the TRICARE patient.

4.6 Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 claim form in the name of the TRICARE patient.

4.7 When a properly preauthorized transplant candidate is discharged less than 24-hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

4.8 Heart-lung and lung transplants performed on an emergency basis in an unauthorized heart-lung or lung transplant facility may be cost-shared only when the following conditions have been met:

4.8.1 The unauthorized center must consult with the nearest TRICARE or Medicare-certified heart-lung or lung transplantation center regarding the transplantation case; and

4.8.2 It must be determined and documented by the transplant team physician(s) at the certified heart-lung or lung transplantation center that transfer of the patient (to the certified heart-lung or lung transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

5.0 EXCLUSIONS

5.1 Expenses waived by the transplant center, (e.g., beneficiary/sponsor not financially liable).

5.2 Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).

5.3 Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off label" drug indication.

5.4 Pre- or post-transplant nonmedical expenses, (e.g., out-of-hospital living expenses, to include hotel, meal, privately owned vehicle for the beneficiary or family members).

5.5 Transportation of an organ donor.

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Chapter 4, Section 24.1

Heart-Lung And Lung Transplantation

5.6 AlloMap® molecular expression testing for cardiac transplant rejection surveillance.

6.0 EFFECTIVE DATES

6.1 February 28, 1991, for heart-lung and lung transplantation.

6.2 May 1, 1996, for epoprostenol.

6.3 June 1, 1997, for living donor lobar lung transplantation.

- END -

5.7 3D rendering (CPT⁶ 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 (CPT⁶ procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

5.9 CT angiography (CPT⁶ procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

5.10 CT, heart, without contrast material, with quantitative evaluation of coronary calcium (CPT⁶ procedure code 75572) 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.

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 1mm 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 CAD with breast MRI (CPT⁶ 0159T) is unproven.

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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 CPT⁷ procedure codes 72291 and 72292.

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.

- END -

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Chapter 7

Medicine

Section/Addendum	Subject/Addendum Title
1.1	Sexual Dysfunctions, Paraphilias, And Gender Identity Disorders
2.1	Clinical Preventive Services - TRICARE Standard
2.2	Clinical Preventive Services - TRICARE Prime
2.3	Family Planning
2.4	Cervical Cancer Screening
2.5	Well-Child Care
2.6	Routine Physical Examinations
2.7	Chelation Therapy
2.8	Hydration, Therapeutic, Prophylactic, And Diagnostic Injections And Infusions
3.1	Limit On Acute Inpatient Mental Health Care
3.2	Limit On Residential Treatment Center (RTC) Care
3.3	Preauthorization Requirements For Acute Hospital Psychiatric Care
3.4	Preauthorization Requirements For Residential Treatment Center (RTC) Care
3.5	Preauthorization Requirements For Substance Use Disorder Detoxification And Rehabilitation
3.6	Psychiatric Partial Hospitalization Programs (PHPs) - Preauthorization And Day Limits
3.7	Substance Use Disorders
3.8	Learning Disorders
3.9	Attention-Deficit/Hyperactivity Disorder
3.10	Treatment Of Mental Disorders
3.11	Ancillary Inpatient Mental Health Services
3.12	Psychological Testing
3.13	Psychotherapy
3.14	Family Therapy
3.15	Psychotropic Pharmacologic Management
3.16	Collateral Visits
3.17	Eating Disorders

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Chapter 7, Medicine

Section/Addendum	Subject/Addendum Title
4.1	Biofeedback
4.2	Dialysis
5.1	Gastroenterology
6.1	Ophthalmological Services
6.2	Lenses (Intraocular Or Contact) And Eye Glasses
6.3	Cardiovascular Therapeutic Services
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Section/Addendum	Subject/Addendum Title
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Hydration, Therapeutic, Prophylactic, And Diagnostic Injections And Infusions

Issue Date:

Authority: [32 CFR 199.4\(b\)\(2\)\(v\)](#), [\(b\)\(3\)\(iii\)](#), [\(b\)\(5\)\(v\)](#), [\(d\)\(3\)\(vi\)](#), [\(e\)\(11\)\(ii\)](#), and [\(g\)\(15\)](#)

1.0 CPT¹ PROCEDURE CODES

96360 - 96379

2.0 HCPCS PROCEDURE CODES

J3487, J3488

3.0 DESCRIPTION

Intravenous (IV) hydration infusion consists of pre-packaged fluid and electrolytes, but not infusion of drugs or other substances. A therapeutic, prophylactic, or diagnostic IV infusion or injection (other than hydration) is for the administration of substances or drugs.

Note: Policy regarding chemotherapy administration is found in [Section 16.3](#).

4.0 POLICY

4.1 Hydration IV infusion consisting of a pre-packaged fluid and electrolytes are covered.

4.2 Intravenous or intra-arterial push (an injection in which the health care professional who administers the substance/drug is continuously present to administer the injection and observe the patient or an infusion of 15 minutes or less) for therapy, prophylactic, or diagnosis is covered.

4.3 Off-label use of zoledronic acid (Zometa®) for treatment of breast cancer may be cost-shared when:

4.3.1 Patient was premenopausal at the time of diagnosis, and has stage I or II breast cancer;

4.3.2 Patient has had surgically induced menopause (e.g., oophorectomy) or has been put temporarily into menopause (chemically induced menopause with Goserelin or similar product) prior to administration of zoledronic acid;

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4.3.3 Patient has hormone receptor (Estrogen Receptor (ER) and/or Progesterone Receptor (PR)) positive disease and zoledronic acid is being used in combination with hormonal therapy (e.g., Tamoxifen, Arimedex®, Aromasin®, Femara®);

4.3.4 No concurrent adjuvant chemotherapy has been given or planned;

4.3.5 Prescriber is an oncologist or an individual highly familiar with prescribing and monitoring of oncology-related medications.

5.0 EFFECTIVE DATE

February 12, 2009, for off-label use of zoledronic acid (Zometa®) for treatment of breast cancer.

- END -

Chemotherapy Administration

Issue Date:

Authority: [32 CFR 199.4\(b\)\(2\)\(v\), \(b\)\(3\)\(iii\), \(b\)\(5\)\(v\), \(d\)\(3\)\(vi\), \(e\)\(11\)\(i\), \(e\)\(11\)\(ii\), \(e\)\(11\)\(iii\), \(g\)\(15\)](#)

1.0 CPT¹ PROCEDURE CODES

96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415 - 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521 - 96523, 96542, 96549

2.0 DESCRIPTION

Chemotherapy administration applies to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided in treatment of noncancerous diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers.

3.0 POLICY

3.1 Chemotherapy administration, subcutaneous or intramuscular; non-hormonal and anti-neoplastic is covered.

3.2 Chemotherapy administration, intralesional, up to and including seven lesions, more than seven lesions, intravenous push technique, single, initial substance/drug, each additional substance/drug is covered.

3.3 Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug; each additional hour, initiation of prolonged chemotherapy infusion (more than 8 hours requiring use of a portable or implantable pump and each additional sequential infusion (different substance/drug) up to one hour) is covered.

3.4 Chemotherapy administration, intra-arterial; push technique/infusion technique, up to one hour; infusion technique, each additional hour up to eight hours infusion technique (more than eight hours) requiring the use of a portable or implantable pump is covered.

3.5 Chemotherapy administration into pleural cavity, requiring and including thoracentesis; into the peritoneal cavity requiring and including peritoneocentesis is covered.

3.6 Chemotherapy administration into Central Nervous System (CNS) (e.g., intrathecal requiring and including spinal puncture) is covered.

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3.7 Refilling and maintenance of portable pump is covered. Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous-interarterial) is covered.

3.8 Irrigation of implanted venous access device for drug delivery systems is covered.

3.9 Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents is covered.

3.10 Paclitaxel (Taxol) is covered for the treatment of breast cancer for the following indications (Healthcare Common Procedure Coding System (HCPCS) code J9265). This is not all inclusive. Other U.S. Food and Drug Administration (FDA)-approved labeled indications of Taxol are also covered):

3.10.1 Adjuvant therapy for node-positive breast cancer when administered sequentially following standard Doxorubicin-containing combination chemotherapy.

3.10.2 Adjuvant therapy for early-stage breast cancer.

3.10.3 First-line therapy for metastatic breast cancer.

- Paclitaxel alone or in combination with Anthracycline (Doxorubicin, Epirubicin) for Anthracycline-naïve patients.
- Paclitaxel for Anthracycline-resistant patients.
- Paclitaxel and Gemcitabine following failure of adjuvant chemotherapy.
- Paclitaxel and Trastuzumab (Herceptin®) for HER-2-positive breast cancer.
- Paclitaxel and Bevacizumab (Avastin™) for HER-2-negative breast cancer.
- Paclitaxel and Carboplatin for HER-2-positive breast cancer.

3.10.4 Second-line therapy for advanced breast cancer for the treatment of breast cancer in patients who have metastatic disease refractory to conventional combination chemotherapy or who have experienced relapse within six months of adjuvant chemotherapy; prior therapy should have included an Anthracycline agent unless clinically contraindicated.

3.11 Paclitaxel protein-bound particles (Abraxane) (HCPCS code J9264) is covered for the treatment of breast cancer after failure of combination chemotherapy for metastatic breast cancer or relapse within six months of adjuvant chemotherapy. (This is not all inclusive. Other FDA-approved labeled indications are also covered.)

4.0 EFFECTIVE DATES

4.1 October 25, 1999 for Paclitaxel (Taxol).

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Chemotherapy Administration

4.2 January 7, 2005, for Paclitaxel protein-bound particles (Abraxane).

- END -

Mucus Clearance Devices

Issue Date: June 5, 1995

Authority: [32 CFR 199.4](#)

1.0 HCPCS PROCEDURE CODES

A7025, A7026, E0480, E0482 - E0484, S8185

2.0 DESCRIPTION

2.1 Mucus clearance devices are designed to clear mucus secretions from the lungs of patients with mucociliary clearance impairment.

2.2 Some mucus clearance devices resemble a combination of a smoker's pipe and a referee's whistle. It consists of a hardened plastic mouthpiece at one end, a plastic perforated cover at the opposite end, and a valve on the inside created by a high-density stainless steel ball resting in a plastic circular cone.

2.3 Other bronchial drainage systems include an air oscillator and an inflatable vest and uses high-frequency chest wall oscillations, which also clear mucus from the airway wall. This type of system is a mechanical form of Chest **Physical Therapy** (CPT) used as an alternative to conventional CPT in patients with **Cystic Fibrosis (CF)**.

3.0 POLICY

3.1 Reimbursement of the mucus clearance device includes CF, Chronic Obstructive Pulmonary Disease (COPD) (which encompasses both chronic bronchitis and emphysema), and other mucus producing lung diseases.

3.2 The mucus clearance device used must be U.S. Food and Drug Administration (FDA) approved. Coverage can only begin effective the date of FDA approval.

4.0 EXCLUSION

Intrapulmonary Percussive Ventilation (IPV) (Healthcare Common Procedure Coding System (HCPCS) code E0481) for the treatment of CF is unproven.

- END -

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