



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 36  
6010.57-M  
SEPTEMBER 9, 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 - JUNE 2010

**CONREQ:** 15102

**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.



**John A. D'Alessandro  
Chief, Medical Benefits and  
Reimbursement Branch**

**ATTACHMENT(S): 33 PAGE(S)  
DISTRIBUTION: 6010.57-M**

**CHANGE 36**  
**6010.57-M**  
**SEPTEMBER 9, 2010**

**REMOVE PAGE(S)**

**CHAPTER 1**

Section 12.1, pages 1 and 2

Section 13.1, pages 1 and 2

**CHAPTER 4**

Section 6.1, pages 1 - 3

Section 13.1, pages 1 and 2

Section 14.1, pages 1 and 2

Section 20.1, pages 1 - 4

Section 24.5, pages 3 and 4

Section 24.6, pages 3 and 4

**CHAPTER 5**

Section 4.1, pages 1 - 4

**APPENDIX A**

pages 21 - 29

**INSERT PAGE(S)**

Section 12.1, pages 1 and 2

Section 13.1, pages 1 and 2

Section 6.1, pages 1 - 3

Section 13.1, pages 1 - 3

Section 14.1, pages 1 and 2

Section 20.1, pages 1 - 4

Section 24.5, pages 3 and 4

Section 24.6, pages 3 and 4

Section 4.1, pages 1 - 4

Pages 21 - 29

## **SUMMARY OF CHANGES**

### **CHAPTER 1**

1. Section 12.1. Added coverage for Category III code 0184T.
2. Section 13.1. Added HCPCS code S2325.

### **CHAPTER 4**

3. Section 6.1. Added core decompression of the femoral head (hip) for early (pre-collapse state I or II) avascular necrosis may be considered for cost-sharing, effective May 1, 2008.
4. Section 13.1. Added coverage for Transanal Endoscopic Microsurgery (TEM) for treatment of benign lesions or T1 tumors when certain conditions are met. Effective date of coverage is June 2, 2009. Radiofrequency Ablation (RFA) for treatment of liver metastases from primary sites other than colorectal metastases is unproven and added as an exclusion.
5. Section 14.1. Posterior Tibial Nerve Stimulation (PTNS) for treatment of overactive bladder, to include urinary frequency, urge and incontinence (CPT procedure code 64555) is unproven and added as an exclusion.
6. Section 20.1. Allows coverage for epidural steroid injections for the treatment of pain due to symptomatic thoracic disc herniation when: 1) pain is radicular and 2) pain is unresponsive to conservative treatment.
7. Section 24.5. Liver transplantation and LDLT is excluded when active alcohol or other substance abuse interferes with compliance to strict treatment regimen.
8. Section 24.6. Combined liver-kidney transplantation is excluded when active alcohol or other substance abuse interferes with compliance to strict treatment regimen.

### **CHAPTER 5**

9. Section 4.1. PET and PET/CT for ruling out recurrence of ovarian cancer as a covered indication. PET and PET/CT for the initial diagnosis staging, and monitoring of treatment of ovarian cancer is added to Exclusions as unproven. PET and PET/CT for staging, restaging and detection of recurrence of colorectal cancer as covered indications. PET and PET/CT for the initial diagnosis and monitoring of treatment of colorectal cancer is added to Exclusions as unproven.

**CHANGE 36  
6010.57-M  
SEPTEMBER 9, 2010**

**SUMMARY OF CHANGES (Continued)**

**APPENDIX A**

10. Added new acronyms.

## Category III Codes

Issue Date: March 6, 2002

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

---

### 1.0 CPT<sup>1</sup> 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](#).

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

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**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 (CPT<sup>2</sup> procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

**5.3** Computer-Aided Detection (CAD) with breast MRI (CPT<sup>2</sup> procedure code 0159T) is unproven.

- END -

---

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

## Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes

Issue Date: November 6, 2007  
Authority:

---

### 1.0 HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

### 2.0 DESCRIPTION

**2.1** HCPCS "C" codes include device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals that do not have other HCPCS assigned.

**2.2** HCPCS "S" codes are temporary codes used by the private sector to report drugs, services, and supplies for which there are no national codes.

### 3.0 POLICY

**3.1** Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For Hospital Outpatient Department (HOPD) services provided on or before May 1, 2009 (implementation of TRICARE's OPPS), and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 24, paragraph 2.2](#).

**3.2** Under TRICARE, "S" codes are not reimbursable except as follows:

**3.2.1** S9122, S9123, and S9124 for the Extended Care Health Option (ECHO) respite care benefit and the ECHO Home Health Care (EHHC) benefit;

**3.2.2** S0812, S1030, S1031, S1040, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2235, **S2325**, S2360, S2361, S2401, S2402, S2403, S2405, S2411, S3620, S3818, S3819, S3820, S3822, S3823, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

**3.2.3** S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 18, Section 9](#).)

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

Chapter 1, Section 13.1

Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes

---

**3.2.4** S2400 for prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with prenatal diagnosis of CDH shall be determined on a case-by-case basis, based on the Rare Disease policy, effective October 1, 2009. Procedural guidelines for review of rare disease are contained in [Section 3.1](#).

**3.3** Under TRICARE, HCPCS code S9999 is a recognized code for purposes of reporting sales tax but is not payable.

**4.0 EXCLUSIONS**

HCPCS "C" codes are not allowed to be billed by independent professional providers.

- END -

## Musculoskeletal System

Issue Date: August 26, 1985

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

---

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

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

### 2.0 HCPCS CODES

**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 (CPT<sup>1</sup> procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT<sup>1</sup> 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) (CPT<sup>1</sup> 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.

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**4.6** Core decompression of the femoral head (hip) for early (precollapse stage I or II) avascular necrosis may be considered for cost-sharing.

## **5.0 EXCLUSIONS**

**5.1** Percutaneous vertebroplasty (CPT<sup>2</sup> procedure codes 22520 - 22525) is unproven.

**5.2** Percutaneous kyphoplasty (CPT<sup>2</sup> procedure codes 22523 - 22525) for the treatment of vertebral fractures is unproven.

**5.3** Meniscal transplant (CPT<sup>2</sup> 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 (CPT<sup>2</sup> procedure codes 20552 and 20553) for migraine headaches.

**5.7** Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT<sup>2</sup> procedure code 22856) each additional interspace (CPT<sup>2</sup> procedure code 0092T) is unproven.

**5.8** Removal of total disc arthroplasty anterior approach cervical; single interspace (CPT<sup>2</sup> procedure code 22864) each additional interspace (CPT<sup>2</sup> procedure code 0095T) is unproven. Also, see [Section 1.1](#).

**5.9** Lumbar total disc arthroplasty (lumbar artificial intervertebral disc revision including replacement, lumbar total disc replacement) for degenerative disc disease is unproven (CPT<sup>2</sup> procedure codes 22857, 22562, 0163T, 0164T, and 0165T).

**5.10** Extracorporeal Shock Wave Therapy (ESWT) for the treatment of plant fasciitis or lateral epicondylitis is unproven.

**5.11** XSTOP Interspinous Process Decompression System for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

**5.12** Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT<sup>2</sup> procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

**5.13** Hip arthroscopy (CPT<sup>2</sup> procedure code 29862) for the treatment of FAI and debridement of articular cartilage is unproven.

**5.14** Femoroplasty (CPT<sup>2</sup> procedure code 29999) for the treatment of FAI syndrome is unproven.

---

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

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

Chapter 4, Section 6.1

Musculoskeletal System

---

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

**5.16** Thermal Intradiscal Procedures (TIPs) (CPT<sup>3</sup> 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.

**6.0 EFFECTIVE DATE**

**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.

- END -

---

<sup>3</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.



## Chapter 4

## Section 13.1

# Digestive System

Issue Date: August 26, 1985

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

---

### 1.0 CPT<sup>1</sup> 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 (CPT<sup>1</sup> 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) (CPT<sup>1</sup> 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) (CPT<sup>1</sup> procedure codes 77600, 77605, and 96445) in conjunction with cytoreductive surgery or peritonectomy for treatment of

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

---

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 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.

**3.5** Transanal Endoscopic Microsurgery (TEM) (CPT<sup>2</sup> 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.

#### 4.0 EXCLUSIONS

**4.1** Vestibuloplasty (CPT<sup>2</sup> 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 (CPT<sup>2</sup> procedure codes 43201 and 43257).

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

**4.4** RFA for treatment of liver metastases from primary sites other than colorectal metastases is unproven (CPT<sup>2</sup> procedure codes 47370, 47380, and 47382).

---

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**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.

- END -

---

<sup>3</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.



## Urinary System

Issue Date: August 26, 1985

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

---

### 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

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

---

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

#### 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.

4.7 Posterior Tibial Nerve Stimulation (PTNS) for treatment of overactive bladder, to include urinary frequency, urge, and incontinence (CPT<sup>2</sup> procedure code 64555), 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.

- END -

---

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

## Chapter 4

## Section 20.1

# Nervous System

Issue Date: August 29, 1985

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

---

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

61000 - 61626, 61680 - 61860, 61863 - 62284, 62290 - 63048, 63055 - 64484, 64505 - 64560, 64565 - 64580, 64595, 64600 - 64650, 64680 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

### 2.0 POLICY

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

**2.2** Therapeutic embolization (CPT<sup>1</sup> procedure code 61624) may be covered for the following indications. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

- Cerebral Arteriovenous Malformations (AVMs).
- Vein of Galen Aneurysm.
- Inoperable or High-Risk Intracranial Aneurysms.
- Dural Arteriovenous Fistulas.
- Meningioma.
- Pulmonary Arteriovenous Malformations (PAVMs).

**2.3** Implantation of depth electrodes is covered. Implantation of a U.S. Food and Drug Administration (FDA) approved vagus nerve stimulator as adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age, which are refractory to anti-epileptic medication is covered. Battery replacement is also covered.

**2.4** Spinal cord and deep brain stimulation are covered in the treatment of chronic intractable pain. Coverage includes:

**2.4.1** The accessories necessary for the effective functioning of the covered device.

**2.4.2** Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**2.5** The Guglielmi Detachable Coil (GDC) may be cost-shared for embolizing unruptured intracranial aneurysms that, because of their morphology, their location, or the patient's general medical condition, are considered by the treating neurosurgical team to be:

**2.5.1** Very high risk for management by traditional operative techniques; or

**2.5.2** Inoperable; or

**2.5.3** For embolizing other vascular malformation such as AVMs and arteriovenous fistulae of the neurovasculature, to include arterial and venous embolizations in the peripheral vasculature.

**2.6** Thoracic epidural steroid injections for the treatment of pain due to symptomatic thoracic disc herniations may be considered for cost-sharing when a patient meets all of the following criteria:

- Pain is radicular; and
- Pain is unresponsive to conservative treatment.

**2.7** Non-pulsed Radiofrequency (RF) denervation (CPT<sup>2</sup> procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic cervical and lumbar facet pain is covered when the following criteria are met:

**2.7.1** No prior spinal fusion surgery in the vertebral level being treated, and

**2.7.2** Low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations; and the pain is not radicular, and

**2.7.3** Pain has failed to respond to three months of conservative management which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program, and

**2.7.4** A trial of controlled diagnostic medial branch blocks under fluoroscopic guidance has resulted in at least a 50% reduction in pain; and

**2.7.5** If there has been a prior successful RF denervation, a minimum time of six months has elapsed since prior RF treatment (per side, per anatomical level of the spine).

### **3.0 EXCLUSIONS**

**3.1** N-butyl-2-cyanoacrylate (Histacryl Bleu®), iodinated poppy seed oils (e.g., Ethiodol®), and absorbable gelatin sponges are not FDA approved.

**3.2** Transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders is unproven.

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

- 3.3** Deep brain neurostimulation in the treatment of insomnia, depression, anxiety, and substance abuse is unproven.
- 3.4** Psychosurgery is not in accordance with accepted professional medical standards and is not covered.
- 3.5** Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.
- 3.6** Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.
- 3.7** Dorsal Root Entry Zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.
- 3.8** Extraoperative electrocortigraphy for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus is unproven.
- 3.9** Neuromuscular Electrical Stimulation (NMES) for the treatment of denervated muscles is unproven.
- 3.10** Stereotactic cingulotomy is unproven.
- 3.11** Sacral nerve neurostimulator (CPT<sup>3</sup> procedure codes 64561, 64581, 64585, and 64590). See [Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).
- 3.12** Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT<sup>3</sup> procedure codes 63050 and 63051).
- 3.13** Balloon angioplasty, intracranial, percutaneous (CPT<sup>3</sup> procedure code 61630) is unproven.
- 3.14** Transcatheter placement of intravascular stent(s) intracranial (e.g., atherosclerotic or venous sinus stenosis) including angioplasty, if performed (CPT<sup>3</sup> procedure code 61635) is unproven.
- 3.15** Balloon dilation of intracranial vasospasm, initial vessel (CPT<sup>3</sup> procedure code 61640) each additional vessel in same family (CPT<sup>3</sup> procedure code 61641) or different vascular family (CPT<sup>3</sup> procedure code 61642) is unproven.
- 3.16** Endoscopic thoracic sympathectomy.
- 3.17** Trigger point injection for migraine headaches.
- 3.18** Botox (chemodenervation), surgical denervation, and muscle resection for migraine headaches are unproven.
- 3.19** Sphenopalatine ganglion block (CPT<sup>3</sup> procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

---

<sup>3</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**3.20** RF denervation (CPT<sup>4</sup> procedure codes 64626, 64627) for the treatment of thoracic facet pain is unproven. Pulsed Radiofrequency Ablation (RFA) for spinal pain is unproven.

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

**3.22** Cryoablation of Occipital Nerve (CPT<sup>4</sup> procedure code 64640) for the treatment of chronic intractable headache is unproven.

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

**3.24** Thermal Intradiscal Procedures (TIPs) (CPT<sup>4</sup> 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 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.

#### **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.

**4.5** June 1, 2004, for Magnetoencephalography.

**4.6** June 10, 2008, for thoracic epidural steroid injections.

**4.7** January 1, 2009, for non-pulsed RF denervation for the treatment of chronic cervical and lumbar facet pain.

- END -

---

<sup>4</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**3.2** Benefits will only be allowed for transplantations performed at a TRICARE or Medicare-certified liver transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a liver 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 in whose jurisdiction the center is located is the certifying authority for TRICARE authorization as a liver transplantation center. Refer to [Chapter 11, Section 7.1](#) for organ transplantation center certification requirements.

**3.3** Liver transplantation will be paid under the **Diagnosis** Related Group (DRG).

**3.4** Claims for transportation of the donor organ and transplantation 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.

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

**3.6** 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.

**3.7** When a properly preauthorized transplantation 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 transplantation 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.

**3.8** Liver or LDLT performed on an emergency basis in an unauthorized liver transplantation facility may be cost-shared only when the following conditions have been met:

**3.8.1** The unauthorized center must consult with the nearest TRICARE or Medicare-certified liver transplantation center regarding the transplantation case;

**3.8.2** It must be determined and documented by the transplantation team physician(s) at the certified liver transplantation center that transfer of the patient (to the certified liver transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate; and

**3.8.3** All other TRICARE contractual requirements have been met.

## **4.0 EXCLUSIONS**

**4.1** Liver transplantation and LDLT is excluded when any of the following contraindications exist:

**4.1.1** Significant systemic or multisystemic disease (other than hepatorenal failure) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

**4.1.2** Active alcohol or other substance abuse that interferes with compliance to strict treatment regimen.

**4.1.3** Malignancies metastasized to or extending beyond the margins of the liver.

**4.2** The following are also excluded:

**4.2.1** Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).

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

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

**4.2.4** Pre- or post-transplantation nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).

**4.2.5** Transportation of an organ donor.

**4.3** Artificial assist devices that are not FDA approved and that are not used in compliance with FDA approved indications.

## **5.0 EFFECTIVE DATES**

**5.1** November 1, 1994, for hepatitis C.

**5.2** December 1, 1996, for hepatitis B.

- END -

facility that is TRICARE-certified as a liver 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 in whose jurisdiction the center is located is the certifying authority for TRICARE approval as a liver transplantation center. Refer to [Chapter 11, Section 7.1](#) for organ transplant center certification requirements.

**3.3** Effective August 1, 2003, CLKTs shall be paid under the assigned **Diagnosis** Related Group (DRG) based on the patient's diagnosis. Claims for admissions prior to August 1, 2003 shall be reimbursed based on billed charges.

**3.4** 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.

**3.5** 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.

**3.6** When a properly preauthorized candidate is discharged less than 24-hours after admission because of extenuating circumstance, 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.

**3.7** CLKTs performed on an emergency basis in an unauthorized liver transplant facility may be cost-shared only when the following conditions have been met:

**3.7.1** The unauthorized center must consult with the nearest TRICARE or Medicare-certified liver transplantation center regarding the transplantation case; and

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

**3.8** This policy does not apply to beneficiaries who become eligible for Medicare coverage due to isolated renal disease. This policy applies only to those individuals suffering from concomitant hepatic and renal failure. Coordination of benefits with Medicare is not required for CLKTs.

## **4.0 EXCLUSIONS**

**4.1** CLKT is excluded when the following contraindications exist:

**4.1.1** Significant systemic or multisystemic disease (other than hepatorenal failure) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

**4.1.2** Active alcohol or other substance abuse **that interferes with compliance to strict treatment regimen.**

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

Chapter 4, Section 24.6

Combined Liver-Kidney Transplantation (CLKT)

---

**4.1.3** Malignancies metastasized to or extending beyond the margins of the liver and/or kidney.

**4.2** The following are also excluded:

**4.2.1** Expenses waived by the transplant center, (i.e., beneficiary/ sponsor not financially liable.)

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

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

**4.2.4** Pre- or post-transplant nonmedical expenses (i.e., out-of-hospital living expenses, to include, hotel, meals, privately owned vehicle for the beneficiary or family members).

**4.2.5** Transportation of an organ donor.

**5.0 EFFECTIVE DATES**

**5.1** November 12, 1992.

**5.2** November 1, 1994, for hepatitis C.

**5.3** December 1, 1996, for hepatitis B.

- END -

## Chapter 5

## Section 4.1

# Nuclear Medicine

Issue Date: June 30, 1993

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

---

### 1.0 CPT<sup>1</sup> PROCEDURE CODE RANGE

78000 - 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) done in test tubes; and
- IVF done in patients.

### 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.

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**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** The diagnosis and management of lung cancer when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

**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 radioimmunoscinigraphy 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** Indium<sup>111</sup> - for detecting the presence and location of myocardial injury in patients with suspected myocardial infarction.

**3.2.5** Indium<sup>111</sup> - 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** Indium<sup>111</sup> 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 (CPT<sup>2</sup> 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 which have been identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

---

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**3.4.3.1** Women who are estrogen-deficient and at a clinical risk of or osteoporosis. Naturally or surgically post-menopausal women who have not been on **long-term** Hormone Replacement Therapy (HRT). However, **current** use of HRT does not preclude estrogen deficiency.

**3.4.3.2** Individuals who have vertebral abnormalities.

**3.4.3.3** Individuals receiving long-term glucocorticoid (steroid) therapy.

**3.4.3.4** Individuals with primary hyperparathyroidism.

**3.4.3.5** Individuals with positive family history of osteoporosis.

**3.4.3.6** Any other high-risk factor identified by ACOG as the standard of care.

#### **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 for the initial diagnosis of differentiated thyroid cancer and for medullary cell thyroid cancer.

**4.4** Ultrasound ablation (destruction of uterin fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT<sup>3</sup> procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

**4.5** PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of gastric cancer is unproven.

**4.6** PET and PET/CT for the initial diagnosis, staging, and monitoring of treatment of ovarian cancer is unproven.

**4.7** PET and PET/CT for the initial diagnosis and monitoring of treatment of colorectal cancer is unproven.

**4.8** Scintimammography (HCPCS code S8080), Breast-Specific Gamma Imaging (BSGI) (CPT<sup>3</sup> 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.

---

<sup>3</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

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

Chapter 5, Section 4.1

Nuclear Medicine

---

- 5.4** January 1, 1991, for SPECT for brain imaging.
- 5.5** October 28, 1996, for <sup>111</sup>In-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.

- END -

TRICARE Policy Manual 6010.57-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

---

PDA	Patent Ductus Arteriosus Personal Digital Assistant
<b>PDD</b>	<b>Percutaneous (or Plasma) Disc Decompression</b>
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
<b>PIRFT</b>	<b>Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)</b>
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization

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

## Appendix A

### Acronyms And Abbreviations

---

PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
<b>PRFA</b>	<b>Percutaneous Radiofrequency Ablation</b>
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time

TRICARE Policy Manual 6010.57-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

---

PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal

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

Appendix A

Acronyms And Abbreviations

---

ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator

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

### Appendix A

#### Acronyms And Abbreviations

---

SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
<b>SSDI</b>	<b>Social Security Disability Insurance</b>
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty

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

### Appendix A

#### Acronyms And Abbreviations

---

TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment

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

### Appendix A

#### Acronyms And Abbreviations

---

TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy

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

Appendix A

Acronyms And Abbreviations

---

TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URF	Unremarried Former Spouses
URL	Universal Resource Locator
US	Ultrasound United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service

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

Appendix A

Acronyms And Abbreviations

---

USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

- END -

