



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 105
6010.54-M
AUGUST 26, 2009

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.54-M, issued August 2002.

CHANGE TITLE: EVOLVING PRACTICES - JULY 2009

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.



Reta Michak
Acting Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 24 PAGE(S)
DISTRIBUTION: 6010.54-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

CHANGE 105
6010.54-M
AUGUST 26, 2009

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 17.1, pages 1 and 2

Section 17.1, pages 1 and 2

CHAPTER 4

Section 6.1, pages 1 and 2

Section 6.1, pages 1 and 2

Section 9.1, pages 3 through 6

Section 9.1, pages 3 through 6

Section 14.1, pages 1 and 2

Section 14.1, page 1 and 2

Section 21.1, pages 1 and 2

Section 21.1, pages 1 and 2

Section 22.2, pages 1 and 2

Section 22.2, pages 1 through 3

CHAPTER 5

Section 1.1, pages 1 through 4, and 7

Section 1.1, pages 1 through 4, and 7

CHAPTER 7

Section 7.1, pages 1 and 2

Section 7.1, pages 1 and 2

Section 18.2, page 3

Section 18.2, page 3

CHAPTER 8

Section 9.1, page 5

Section 9.1, page 5

SUMMARY OF CHANGES

CHAPTER 1

1. Section 17.1. Cross-reference correction.

CHAPTER 4

2. Section 6.1. Total Ankle Replacement (TAR) CPT Codes 27702 and 27703, now proven, removed from the No Government Pay List (NGPL), and added coverage language to the TRICARE Policy Manual. Revised CPT codes for exclusions of total disc arthroplasty, removal and total disc arthroplasty, and artificial intervertebral disc replacement due to coding changes that were effective January 1, 2009.
3. Section 9.1. Corrected two typographical errors.
4. Section 14.1. Added an Exclusion: Cryoablation for the treatment of renal angiomyolipoma is unproven.
5. Section 21.1. Added an Exclusion: Optonol ExPRESS Miniature Tube Shunt in the treatment of glaucoma is unproven.
6. Section 22.2. Revised policy and added coverage for unilateral and bilateral cochlear implantation for children and adults.

CHAPTER 5

7. Section 1.1. Paragraph IV.B. Added clarification that this list of indications is not all inclusive. Other indications may be covered when documented by reliable evidence as safe, effective, and comparable to conventional technology (proven). Also adds an additional covered indication 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.

CHAPTER 7

8. Section 7.1 Adds two CPT codes for auditory rehabilitation services in conjunction with the revised policy on cochlear implantation in Chapter 4, Section 22.2.
9. Section 18.2. Revises the policy to exclude Spinalator Therapy and Spinalator Table as unproven.

CHANGE 105
6010.54-M
AUGUST 26, 2009

SUMMARY OF CHANGES (Continued)

CHAPTER 8

10. Section 9.1. Adds irinotecan (Camptosar™) for the treatment of metastatic esophageal cancer as an exclusion because it is unproven.