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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 136
6010.54-M
MARCH 21, 2011**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), AUGUST 2002**

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

CHANGE TITLE: EVOLVING PRACTICES - FEBRUARY 2011

CONREQ: 15287

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

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

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ATTACHMENT(S): 9 PAGE(S)
DISTRIBUTION: 6010.54-M

CHANGE 136
6010.54-M
MARCH 21, 2011

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 4

Section 20.1, pages 3 - 5

Section 20.1, pages 3 - 5

CHAPTER 5

Section 4.1, pages 1 - 4

Section 4.1, pages 1 - 4

CHAPTER 7

Section 27.1, pages 1 and 2

Section 27.1, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 4

1. Section 20.1. Added coverage for endoscopic laminotomy for the treatment of lumbar spinal stenosis. The endoscopic spinal system used in the procedure must be FDA approved. Effective date of coverage is January 1, 2009. Laser ablation of paravertebral facet joint is unproven and added as an exclusion.

CHAPTER 5

2. Section 4.1. Added coverage for PET/CT for metastatic bladder cancer. Effective date of coverage is January 1, 2010.

CHAPTER 7

3. Section 27.1. Botox (OnabotulinumtoxinA) and Myobloc (RimabotulinumtoxinB) injections may be considered for off-label cost-sharing for the treatment of sialorrhea associated with anticholinergics. Effective date of coverage October 1, 2009.

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.

F. 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:

1. Pain is radicular; and
2. Pain is unresponsive to conservative treatment.

G. Non-pulsed Radiofrequency (RF) denervation (CPT³ procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic cervical and lumbar facet pain is covered when the following criteria are met:

1. No prior spinal fusion surgery in the vertebral level being treated, and
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
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
4. A trial of controlled diagnostic medial branch blocks under fluoroscopic guidance has resulted in at least a 50% reduction in pain; and
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).

H. Endoscopic laminotomy (CPT³ procedure code 63030) is covered for the treatment of lumbar spinal stenosis. The endoscopic spinal system used in the procedure must be FDA approved.

IV. EXCLUSIONS

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

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

C. Deep brain neurostimulation in the treatment of insomnia, depression, anxiety, and substance abuse is unproven.

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D. Psychosurgery is not in accordance with accepted professional medical standards and is not covered.

E. Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.

F. Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.

G. Dorsal Root Entry Zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

H. Extraoperative electrocortigraphy for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus is unproven.

I. Neuromuscular Electrical Stimulation (NMES) for the treatment of denervated muscles is unproven.

J. Stereotactic cingulotomy is unproven.

K. Sacral nerve neurostimulator (CPT⁴ procedure codes 64561, 64581, 64585, and 64590). See [Chapter 4, Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

L. Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT⁴ procedure codes 63050 and 63051).

M. Balloon angioplasty, intracranial, percutaneous (CPT⁴ procedure code 61630) is unproven.

N. Transcatheter placement of intravascular stent(s) intracranial (e.g., atherosclerotic or venous sinus stenosis) including angioplasty, if performed (CPT⁴ procedure code 61635) is unproven.

O. Balloon dilation of intracranial vasospasm, initial vessel (CPT⁴ procedure code 61640) each additional vessel in same family (CPT⁴ procedure code 61641) or different vascular family (CPT⁴ procedure code 61642) is unproven.

P. Sphenopalatine ganglion block (CPT⁴ procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

Q. RF denervation (CPT⁴ procedure codes 64626, 64627) for the treatment of thoracic facet pain is unproven. Pulsed Radiofrequency Ablation (RFA) for spinal pain is unproven.

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

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S. Cryoablation of Occipital Nerve (CPT⁵ procedure code 64640) for the treatment of chronic intractable headache is unproven.

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

U. Thermal Intradiscal Procedures (TIPs) (CPT⁵ 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 Diskectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

V. Laser ablation of paravertebral facet joint nerves (CPT⁵ procedure codes 64622 and 64623) is unproven. (This applies only to laser ablation and should not be applied to RFA.)

V. EFFECTIVE DATES

A. January 1, 1989, for PAVM.

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

C. July 14, 1997, for GDC.

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

E. June 1, 2004, for Magnetoencephalography.

F. June 10, 2008, for thoracic epidural steroid injections.

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

H. January 1, 2009, for endoscopic laminotomy for the treatment of lumbar spinal stenosis.

- END -

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NUCLEAR MEDICINE

ISSUE DATE: June 30, 1993

AUTHORITY: 32 CFR 199.4(b)(2)(vii) and (c)(2)(ix)

I. CPT¹ PROCEDURE CODE RANGE

78000 - 79999

II. 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 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: (1) Planar, Single Photon Emission Computed Tomography (SPECT); (2) Positron Emission Tomography (PET); (3) Tomography; (4) Nuclear Medicine Scan; (5) Radiopharmaceutical; (6) Gamma Camera; (7) In Vitro done in test tubes; and (8) In Vitro done in patients.

III. POLICY

A. Positron emission tomography (PET) is covered for:

1. The diagnosis and management of seizure disorders.
2. Evaluation of ischemic heart disease.
3. The diagnosis and management of lung cancer.
4. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of lymphoma.
5. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of pancreatic cancer.

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6. PET and PET/CT for the staging and restaging of differentiated (follicular, papillary, Hürthle cell) thyroid cancer.
7. PET and PET/CT for ruling out recurrence of ovarian cancer.
8. PET and PET/CT for staging, restaging, and detection of recurrence of colorectal cancer.
9. **PET/CT for metastatic bladder cancer.**
10. PET scans for other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

B. Single Photon Emission Computed Tomography (SPECT) is covered for:

1. Myocardial perfusion imaging utilizing SPECT.
2. Brain imaging utilizing SPECT for the evaluation of seizure disorder.
3. Prostatic radioimmunoscinigraphy imaging utilizing SPECT for the following indications:
 - a. Metastatic spread of prostate cancer and for use in post-prostatectomy patients in whom there is a high suspicion of undetected cancer recurrence.
 - b. Newly diagnosed patients with biopsy-proven prostate cancer at high risk for spread of their disease to pelvic lymph nodes.
4. Indium¹¹¹ - for detecting the presence and location of myocardial injury in patients with suspected myocardial infarction.
5. Indium¹¹¹ - labeled anti-TAG72 for tumor recurrence in colorectal and ovarian cancer.
6. SPECT for other indications is covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

C. Indium¹¹¹ Pentetreotide (Octreoscan) Scintigraphy is covered for:

1. The localization and monitoring of treatment of primary and metastatic neuroendocrine tumors.
2. Other indications when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

D. Bone Density Studies (CPT² procedure codes 78350, 78351) are covered for:

1. The diagnosis and monitoring of osteoporosis.
2. The diagnosis and monitoring of osteopenia.

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:

a. 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.

b. Individuals who have vertebral abnormalities.

c. Individuals receiving long-term glucocorticoid (steroid) therapy.

d. Individuals with primary hyperparathyroidism.

e. Individuals with positive family history of osteoporosis.

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

IV. EXCLUSIONS

A. Bone density studies for the routine screening of osteoporosis.

B. PET for the diagnosis and monitoring of treatment of Alzheimer's disease, fronto-temporal dementia or other forms of dementia is unproven.

C. PET and PET/CT for the initial diagnosis of differentiated thyroid cancer and for medullary cell thyroid cancer.

D. Ultrasound ablation (destruction of **uterine** fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT² procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

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

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

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 4.1

NUCLEAR MEDICINE

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

H. Scintimammography (HCPCS code S8080), Breast-Specific Gamma Imaging (BSGI) (CPT³ procedure codes 78800, 78801), and Molecular Breast Imaging (MBI) are unproven for all indications.

V. EFFECTIVE DATES

A. January 1, 1995, for PET for ischemic heart disease.

B. December 1, 1996, for PET for lung cancer.

C. October 14, 1990, for SPECT for myocardial perfusion imaging.

D. January 1, 1991, for SPECT for brain imaging.

E. October 28, 1996, for ¹¹¹In-Capromab Pendetide, CyT 356 (ProstaScint™).

F. June 1, 1994, for Octreoscan Scintigraphy.

G. May 26, 1994, for bone density studies.

H. January 1, 2007, for PET and PET/CT for lymphoma.

I. January 1, 2006, for PET and PET/CT for pancreatic cancer.

J. February 16, 2006, for PET and PET/CT for thyroid cancer.

K. December 1, 2008, for PET and PET/CT for ruling out recurrence of ovarian cancer.

L. May 1, 2007, for PET and PET/CT for staging, restaging, and detection of recurrence of colorectal cancer.

M. January 1, 2010, for PET/CT for metastatic bladder cancer.

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BOTULINUM TOXIN A INJECTIONS

ISSUE DATE: October 12, 1998

AUTHORITY: 32 CFR 199.4(c)(2)(iii) and (c)(2)(iv)

I. CPT¹ PROCEDURE CODES

46505, 64612 - 64614, 64640, 64653, 67345

II. DESCRIPTION

These procedures involve the injection of small amounts of botulinum toxin type A into selected muscles for the nonsurgical treatment of the conditions relating to spasticity, various dystonias, nerve disorders, and muscular tonicity deviations.

III. POLICY

A. Botulinum toxin A injections may be considered for cost-sharing for treating conditions such as cervical dystonia (repetitive contraction of the neck muscles) in decreasing the severity of abnormal head position and neck pain for patients 16 years and older.

B. Botulinum toxin A injections may be considered for cost-sharing for treating conditions such as blepharospasm (spasm of the eyelids/uncontrolled blinking) and strabismus (squinting/eyes do not point in the same direction) associated with dystonia, including benign essential blepharospasm or VII nerve disorders for patients 12 years of age and older.

C. Botulinum toxin A injections may be considered for cost-sharing for treating conditions such as severe primary axillary hyperhidrosis (severe underarm sweating) that is inadequately managed by topical agents for patients 18 years of age and older.

D. Botox® (chemodenervation-CPT¹ procedure code 46505) may be considered for off-label cost-sharing for the treatment of chronic anal fissure unresponsive to conservative therapeutic measures, effective May 1, 2007.

E. Botulinum toxin A injections may be considered for off-label cost-sharing for the treatment of spasticity resulting from Cerebral Palsy (CP), effective November 1, 2008.

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F. Botox® (OnabotulinumtoxinA) and Myobloc® (RimabotulinumtoxinB) injections may be considered for off-label cost-sharing for the treatment of sialorrhea associated with Parkinson disease patients who are refractory to, or unable to tolerate, systemic anticholinergics, effective October 1, 2009.

IV. EXCLUSIONS

A. Botulinum toxin A injections are unproven for the following indications:

1. Palmar hyperhidrosis.
2. Urinary urge incontinence.
3. Lower back pain/lumbago.
4. Migraine headaches and other primary headache disorders.

B. Botox® (chemodenervation-CPT² procedure code 64612) for the treatment of muscle spasms secondary to cervical degenerative disc disease and spinal column stenosis is unproven.

V. EFFECTIVE DATE

A. May 1, 2007, for coverage of chronic anal fissure unresponsive to conservative therapeutic measures (CPT² procedure code 46505).

B. October 1, 2009, for coverage of sialorrhea associated with Parkinson disease patients who are refractory to, or unable to tolerate systemic anticholinergics (CPT² procedure code 64653).

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