



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 138
6010.54-M
MAY 3, 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 - APRIL 2011

CONREQ: 15347

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.

**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 10 PAGE(S)
DISTRIBUTION: 6010.54-M**

CHANGE 138
6010.54-M
MAY 3, 2011

REMOVE PAGE(S)

CHAPTER 1

Section 3.1, pages 1 and 2

CHAPTER 5

Section 3.1, pages 3 - 5

CHAPTER 7

Section 3.10, page 3

Section 27.1, pages 1 and 2

INDEX

pages 23 and 24

INSERT PAGE(S)

Section 3.1, pages 1 and 2

Section 3.1, pages 3 - 5

Section 3.10, page 3

Section 27.1, pages 1 and 2

pages 23 and 24

SUMMARY OF CHANGES

CHAPTER 1

1. Section 3.1. Added post-operative proton beam radiosurgery/radiotherapy (CPT procedures codes 77520, 77522, 77523, 77525) may be considered for cost-sharing when the diagnosis is sacral chordoma.

CHAPTER 5

2. Section 3.1. Added post-operative therapy for sacral chordoma under the rare disease policy as described in Chapter 1, Section 3.1., to the list of covered indications.

CHAPTER 7

3. Section 3.10. Transcranial Magnetic Stimulation (TMS) (also referred to as repetitive TMS (rTMS)) for the treatment of major depressive disorder (CPT procedure codes 90867 and 90868), was added to EXCLUSIONS as unproven.
4. Section 27.1.
5. Added coverage for Botulinum toxin A (OnabotulinumtoxinA) injections for prophylaxis of headaches in adult patients with chronic migraine, which is defined as 15 days or more per month with headache lasting four hours a day or longer. Effective date of coverage, October 15, 2010.

INDEX

6. Added Transcranial Magnetic Stimulation (TMS).

RARE DISEASES

ISSUE DATE: May 18, 1994

AUTHORITY: 32 CFR 199.2(b) and 32 CFR 199.4(g)(15)

I. DESCRIPTION

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

II. POLICY

A. 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.

B. 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.

1. Trials published in refereed medical literature.
2. Formal technology assessments.
3. National medical policy organization positions.
4. National professional associations.
5. National expert opinion organizations.

C. 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.

D. 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.

E. 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.

F. Effective May 13, 2009, Intraperitoneal Hyperthermic Chemotherapy (IPHC) (CPT¹ 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:

1. There is no evidence of distant metastasis.
2. There is evidence of low histological aggressiveness of the disease.
3. The patient has not undergone preoperative systemic chemotherapy.
4. The patient's condition does not preclude major surgery.
5. The chemotherapeutic agents used are Mitomycin C, Cisplatin (also known as Cisplatinum), or Fluorouracil.

G. External Infusion Pumps (EIPs) for insulin may be considered for cost-sharing when the diagnosis is Cystic Fibrosis-Related Diabetes (CFRD) with fasting hyperglycemia. See [Chapter 8, Section 2.3](#) for policy regarding EIPs. Effective January 21, 2009.

H. Post-operative proton beam radiosurgery/radiotherapy (CPT¹ procedures codes 77520, 77522, 77523, and 77525) may be considered for cost-sharing when the diagnosis is sacral chordoma. See [Chapter 5, Section 3.1](#) for policy regarding proton beam radiosurgery/radiotherapy.

III. 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 -

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

5. Prostate cancer.
6. Meningioma.
7. Low grade glioma (astrocytoma, grade I-II).
8. Glioblastoma multiforme.
9. Soft tissue sarcoma (liposarcoma).
10. Hodgkin's disease when conventional radiotherapy is contraindicated.
11. Acoustic neuromas.

12. As post-operative therapy for sacral chordoma under the rare disease policy as described in Chapter 1, Section 3.1.

F. Helium ion beam radiosurgery/radiotherapy is covered for the following indications. This 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).

1. As primary therapy for patients with melanoma of the uveal tract, with no evidence of metastasis or extrascleral extension, and with tumors up to 24 mm in largest diameter and 14 mm in height.

2. As postoperative therapy in patients who have undergone biopsy or partial resection of the chordoma or low grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine.

G. Extracranial stereotactic radiosurgery/radiotherapy is covered for the following indication. This 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).

1. Primary and metastatic lung carcinoma.

H. Frameless stereotaxy (neuronavigation) is covered for the following indications. This 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).

1. Localization, surgical planning and guidance for intracranial tumors, skull base tumors, metastatic brain tumors, AVMs, cavernomas, chordomas, and pituitary adenomas.

2. Biopsy guidance.
3. Cerebrospinal fluid shunt placement.
4. Surgery for intractable epilepsy.

5. Spinal surgery.

I. The frameless stereotaxy device must be FDA-approved. The following devices are FDA-approved: StealthStation System, The Operating Arm, ISG Viewing Wand, MKM System, and Philips Easyguide. Other systems which are FDA-approved are also covered.

J. High energy neutron radiation treatment (CPT² procedure codes 77422 and 77423) is covered for adenoid cystic carcinoma for the following indications:

1. Unresectable, inoperable or recurrent tumors.
2. Locally advanced disease.
3. In situations where surgical extirpation would cause considerable morbidity.

IV. EXCLUSIONS

A. Whole body hyperthermia in the treatment of cancer is unproven. Hyperthermia for recurrent breast cancer is unproven.

B. Helium ion beam radiosurgery/radiotherapy for arteriovenous malformations and ependymoma is unproven.

C. Intra-Operative Radiation Therapy (IORT) is unproven.

D. High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking (CPT² procedure code 77422) is unproven (except for treatment of adenoid cystic carcinoma, see [paragraph III.J.](#)).

E. High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking one or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s) (CPT² procedure code 77423) is unproven (except for treatment of adenoid cystic carcinoma, see [paragraph III.J.](#)).

V. EFFECTIVE DATES

A. February 26, 1986, for proton beam radiosurgery/radiotherapy for arteriovenous malformations.

B. March 1, 1988, for proton beam radiosurgery/radiotherapy for patients with Cushing's disease or acromegaly caused by pituitary microadenoma.

C. October 6, 1988, for gamma beam (gamma knife) radiosurgery/radiotherapy for treatment of arteriovenous malformation, benign brain tumors, acoustic neuromas, pituitary

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

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 3.1

RADIATION ONCOLOGY

adenomas, craniopharyngiomas, other tumors of the posterior fossa and pineal region tumors.

D. January 1, 1990, for proton beam radiosurgery/radiotherapy for soft tissue sarcoma (liposarcoma).

E. June 18, 1990, for proton beam radiosurgery/radiotherapy for chordomas or chondrosarcomas.

F. January 1, 1994, for gamma beam (gamma knife) and linear accelerator radiosurgery/radiotherapy for metastatic brain tumors.

G. January 1, 1996, for proton beam radiosurgery/radiotherapy for uveal melanoma.

H. January 1, 1996, for helium ion beam radiosurgery/radiotherapy for uveal melanoma and chordomas or chondrosarcomas.

I. April 1, 1996, for linear accelerator radiosurgery/radiotherapy for arteriovenous malformations and acoustic neuromas.

J. April 26, 1996, for proton beam radiosurgery/radiotherapy for prostate cancer.

K. October 1, 1997, for gamma knife radiosurgery/radiotherapy for high grade gliomas (glioblastoma multiforme, anaplastic astrocytomas).

L. January 1, 1998, for extracranial stereotactic radiosurgery/radiotherapy for lung carcinoma.

M. The date of FDA approval for frameless stereotaxy.

- END -

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 3.10

TREATMENT OF MENTAL DISORDERS

C. Specific developmental disorders.

D. Home visits for individual, family, or marriage counseling (CPT³ procedure code 99510).

E. Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy.

F. Transcranial Magnetic Stimulation (TMS) (also referred to as repetitive TMS (rTMS)) for the treatment of major depressive disorder (CPT³ procedure codes 90867 and 90868), is unproven

V. EFFECTIVE DATE November 13, 1984.

- END -

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

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.

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

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 27.1

BOTULINUM TOXIN A INJECTIONS

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.

G. Botulinum toxin A (OnabotulinumtoxinA) injections for prophylaxis of headaches in adult patients with chronic migraine, which is defined as 15 days or more per month with headache lasting four hours a day or longer.

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. Episodic migraine, chronic daily headache, cluster headache, cervicogenic headache, and tension-type headache.

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 DATES

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).

C. October 15, 2010, coverage for prophylaxis of headaches in adult patients with chronic migraine, which is defined as 15 days or more per month with headache lasting four hours a day or longer.

- END -

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

INDEX	CHAPTER	SECTION
T		
Telemental Health (TMH)/Telemedicine	7	22.1
Therapeutic Apheresis	4	9.4
Therapeutic Shoes For Diabetics	8	8.2
Thermography	5	5.1
Transcranial Magnetic Stimulation (TMS)	7	3.10
Transfusion Services For Whole Blood, Blood Components And Blood Derivatives	6	2.1
Transitional Assistance Management Program (TAMP)	10	5.1
Transitional Survivor Status	10	7.1
Transjugular Intrahepatic Portosystemic Shunt (TIPS)	4	10.1
Transplant		
Combined Heart-Kidney (CHKT)	4	24.3
Combined Liver-Kidney (CLKT)	4	24.6
Combined Small Intestine-Liver (SI/L)	4	24.4
Donor Costs	4	24.9
Heart	4	24.2
Heart-Lung	4	24.1
Kidney	4	24.8
Liver	4	24.5
Living Donor Liver (LDLT)	4	24.5
Lung	4	24.1
Multivisceral	4	24.4
Pancreas-After-Kidney (PAK)	4	24.7
Pancreas-Transplant-Alone (PTA)	4	24.7
Pancreatic Islet Cell	4	24.7
Simultaneous Pancreas-Kidney (SPK)	4	24.7
Small Intestine (SI)	4	24.4
Treatment Of Mental Disorders	7	3.10
TRICARE For Life (TFL)	10	6.1
TRICARE Overseas Program (TOP)		
Audits, Inspections, Reports, And Plans	12	11.2
Authorization Requirements	12	8.1
Benefits And Beneficiary Payments	12	2.1

INDEX

CHAPTER SECTION

T (Continued)

TRICARE Overseas Program (TOP) (Continued)		
Catastrophic Loss Protection (Prime)	12	2.3
Clinical Preventive Services (Prime/Standard)	12	2.2
Continued Health Care Benefit Program (CHCBP) Overseas	12	3.4
Eligibility Requirements	12	3.1
Enrollment (Prime/TRICARE Plus)	12	3.2
Extended Care Health Option (ECHO) - General	12	9.1
Figures	12	12.2
Foreign Claims For Dates Of Service On Or After October 1, 1997	12	11.1
Health Care Finders (HCF)	12	5.1
Host Nation Provider	12	4.1
Introduction	12	1.1
Managed Care Support Contractor (MCSC)		
Responsibilities For Claims Processing	12	11.1
Partnership Program (Reserved)	12	4.2
Payment Policy	12	10.1
Point Of Contact (POC) Program	12	12.1
Point Of Service (POS) Option (Prime)	12	10.2
Primary Care Managers (PCM) (Prime)	12	6.1
Prime And Status Changes	12	3.3
Provision Of Respite Care For The Benefit Of Seriously Ill Or Injured Active Duty Members	12	9.2
Sample Of Overseas Regional Director TOP Preferred Provider Network Agreements	12	7.1, Enc 1
Transitional Assistance Management Program (TAMP) Overseas	12	3.5
TRICARE Area Office (TAO) Director Requirements	12	7.1
TRICARE Reserve And National Guard Family Member Benefits	10	8.1