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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 143
6010.54-M
JUNE 29, 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 - JUNE 2011

CONREQ: 15402

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): 12 PAGE(S)
DISTRIBUTION: 6010.54-M**

CHANGE 143
6010.54-M
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REMOVE PAGE(S)

CHAPTER 1

Section 3.1, pages 1 and 2

Section 16.1, pages 1 and 2

CHAPTER 4

Section 6.1, pages 1 - 3

Section 9.2, page 1

CHAPTER 5

Section 1.1, pages 7 and 8

CHAPTER 7

Section 27.1, pages 1 and 2

INSERT PAGE(S)

Section 3.1, pages 1 and 2

Section 16.1, pages 1 and 2

Section 6.1, pages 1 - 3

Section 9.2, page 1

Section 1.1, pages 7 and 8

Section 27.1, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 1

1. Section 3.1. Added Extracorporeal photopheresis is proven and may be considered for cost-sharing when the diagnosis is Bronchiolitis Obliterans Syndrome (BOS).
2. Section 16.1. XSTOP Interspinous Process Decompression System remains unproven and was added as an exclusion.

CHAPTER 4

3. Section 6.1.
 - a. Added CPT Codes and HCPCS code for the XSTOP Interspinous Process Decompression System which remains unproven and listed as an exclusion.
 - b. Repositioned and clarified existing language for hip arthroscopy in the EXCLUSION listing.
4. Section 9.2. Extracorporeal photopheresis for the treatment of Bronchiolitis Obliterans Syndrome (BOS) that is refractory to immunosuppressive drug treatment is proven and may be considered for cost-sharing under the rare disease policy.

CHAPTER 5

5. Section 1.1. Spelled out acronym CAD as "Computer-Aided Detection" since CAD, meaning Coronary Artery Disease is used in the same section.

CHAPTER 7

6. Section 27.1. Botulinum toxin A injections to treat spasticity in flexor muscles of the elbow, wrist, and finger (upper limb spasticity) in adults is proven and added for coverage, effective March 9, 2010.

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 procedure 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.

I. Extracorporeal photopheresis (CPT¹ procedure code 36522) may be considered for cost-sharing when the diagnosis is Bronchiolitis Obliterans Syndrome (BOS) that is refractory to immunosuppressive drug treatment. See [Chapter 4, Section 9.2](#) for policy regarding photopheresis.

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 -

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CATEGORY III CODES

ISSUE DATE: March 6, 2002

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

I. CPT¹ PROCEDURE CODES

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

II. 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.

III. POLICY

A. 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.

B. Category III codes are excluded from coverage since clinical safety and efficacy or applicability to clinical practice has not been established.

IV. EXCEPTIONS

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

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

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

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

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

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CHAPTER 1, SECTION 16.1

CATEGORY III CODES

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

V. EXCLUSIONS

A. Unlisted codes for Category III codes. Effective January 1, 2002.

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

C. Computer-Aided Detection (CAD) with breast MRI (CPT² procedure code 0159T) is unproven.

D. XSTOP Interspinous Process Decompression System (CPT² procedure codes 0171T and 0172T, HCPCS code C1821) is unproven.

- END -

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MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

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

II. HCPCS CODES

[S2325](#), S2360, S2361

III. DESCRIPTION

The musculoskeletal system pertains to or comprises the skeleton and the muscles.

IV. POLICY

A. 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.

B. 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.

C. Single or multilevel anterior cervical microdiscectomy with allogenic or autogenic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

D. Percutaneous vertebroplasty (CPT¹ procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes 22523-22525) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

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E. Total Ankle Replacement (TAR) (CPT² 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.

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

V. EXCLUSIONS

A. Meniscal transplant (CPT² procedure code 29868) for meniscal injury is unproven.

B. Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.

C. Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (Healthcare Common Procedure Coding System (HCPCS) procedure code M0076) are unproven.

D. Trigger point injection (CPT² procedure codes 20552 and 20553) for migraine headaches.

E. Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT² procedure code 22856) each additional interspace (CPT² procedure code 0092T) is unproven.

F. Removal of total disc arthroplasty anterior approach cervical; single interspace (CPT² procedure code 22864) each additional interspace (CPT² procedure code 0095T) is unproven. Also see [Chapter 4, Section 1.1](#).

G. Lumbar total disc arthroplasty (lumbar artificial intervertebral disc replacement, lumbar total disc replacement) for degenerative disc disease is unproven (CPT² procedure codes 22857, 22862, 0163T, 0164T, and 0165T).

H. Extracorporeal shock wave, high energy involving the plantar fascia (CPT² procedure code 28890).

I. X STOP Interspinous Process Decompression System (CPT² procedure codes 0171T and 0172C, HCPCS code C1821) for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

J. Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT² procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

K. Hip arthroscopy with debridement of articular cartilage (CPT² procedure code 29862) for the treatment of FAI is unproven.

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CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

L. Femoroplasty (CPT³ procedure code 29999) for the treatment of FAI syndrome is unproven.

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

N. Thermal Intradiscal Procedures (TIPs) (CPT³ procedure codes 22526, 22527, 62287, and 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 disectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

O. Total hip resurfacing (HCPCS code S2118) for treatment of degenerative hip disease is unproven.

VI. EFFECTIVE DATES

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

B. May 1, 2008, for Total Ankle Replacement (TAR).

C. May 1, 2008, for core decompression of the femoral head.

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PHOTOPHERESIS

ISSUE DATE: June 30, 1993

AUTHORITY: [32 CFR 199.4\(b\)\(2\)](#) and [\(c\)\(2\)](#)

I. CPT¹ PROCEDURE CODE

36522

II. DESCRIPTION

Photopheresis is a type of plasmapheresis during which white blood cells and some plasma is exposed to **U**ltraviolet (UV) light before being returned to the patient. |

III. POLICY

Photopheresis is covered for the following:

A. The treatment of skin manifestations of **C**utaneous **T-Cell L**ymphoma (CTCL) in persons who have not been responsive to other forms of treatment. |

B. The prevention of rejection in cardiac transplantation.

C. **Extracorporeal photopheresis for the treatment of Bronchiolitis Obliterans Syndrome (BOS) that is refractory to immunosuppressive drug treatment may be considered for cost-sharing under the rare disease policy as described in [Chapter 1, Section 3.1](#).** |

D. For other indications when reliable evidence supports that photopheresis is safe, effective and comparable or superior to standard care (proven).

- END -

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B. Ultrafast CT (electron beam CT (HCPCS code S8092)) to predict asymptomatic heart disease is preventive. **Ultrafast CT (electron beam CT) is excluded for symptomatic patients and for screening asymptomatic patients for CAD.**

C. MRIs (CPT⁶ procedure codes 77058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.

D. MRIs (CPT⁶ procedure codes 77058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.

E. 3D rendering (CPT⁶ procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

F. 3D rendering (CPT⁶ procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

G. 3D rendering (CPT⁶ procedure codes 76376 and 76377) for use as a screening test for CAD in healthy individuals or in asymptomatic patients who have one or more traditional risk factors for CAD is unproven.

H. CT angiography (CPT⁶ procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

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

J. CT, heart, without contrast **material, with** quantitative evaluation of coronary calcium (CPT⁶ procedure code 75571) is excluded for patients **with typical anginal chest pain with high suspicion of CAD; patients with acute MI;** and for screening asymptomatic patients for CAD.

K. CT, heart, with contrast material, **for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)** (CPT⁶ procedure code 75572) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

L. **CT, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)** (CPT⁶ procedure code 75573) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

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CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

M. Computed tomographic angiography heart, coronary arteries and bypass (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) (CPT⁷ procedure code 75574) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

N. Multislice or multidetector row CT angiography of less than 16 slices per sec and 1mm or less resolution is excluded.

O. Dual Energy X-Ray Absorptiometry (DXA) composition study (CPT⁷ procedure code 0028T) is unproven.

P. Computer-Aided Detection with breast MRI (CPT⁷ procedure code 0159T) is unproven.

VI. EFFECTIVE DATES

A. The effective date for MRIs with contrast media is dependent on the U.S. Food and Drug Administration (FDA) approval of the contrast media and a determination by the contractor of whether the labeled or unlabeled use of the contrast media is medically necessary and a proven indication.

B. March 31, 2006, for breast MRI.

C. March 31, 2006, for coverage of multislice or multidetector row CT angiography.

D. January 1, 2007, for CPT⁷ procedure codes 72291 and 72292.

E. January 1, 2007, for coverage of multislice or multidetector row CT angiography performed for presurgical evaluation prior to electrophysiological procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

F. October 1, 2008, for breast MRI for guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

G. October 3, 2006, for CMR.

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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.

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.

H. Botulinum toxin A (OnabotulinumtoxinA) injections to treat spasticity in flexor muscles of the elbow, wrist, and fingers (upper limb spasticity) in adults.

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.

D. March 9, 2010, coverage for spasticity in flexor muscles of the elbow, wrist, and fingers (upper limb spasticity) in adults.

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