



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 147  
6010.54-M  
SEPTEMBER 16, 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 - AUGUST 2011

**CONREQ:** 15484

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

**CHANGE 147**  
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**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 4**

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**CHAPTER 6**

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**CHAPTER 7**

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## **SUMMARY OF CHANGES**

### **CHAPTER 4**

1. Section 6.1. Under EXCLUSIONS, added spinal manipulation under anesthesia (CPT procedure codes 00640 and 22505) for the treatment of back pain is unproven.
2. Section 13.1. Under EXCLUSIONS, added Cytoreductive Surgery (CRS) and Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for treatment of Peritoneal Carcinomatosis (PC) from colorectal cancer.

### **CHAPTER 6**

3. Section 1.1. Under EXCLUSIONS, added OVA1™ test for ovarian cancer. Added the Pathwork Tissue® of Origin Test is unproven to assist in identifying the origin of poorly differentiated, undifferentiated, or metastatic tumors.

### **CHAPTER 7**

4. Section 16.3. Added and EXCLUSION, Cytoreductive Surgery (CRS) and Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for treatment of Peritoneal Carcinomatosis (PC) for colorectal cancer.  
Repositioned the EFFECTIVE DATES.



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CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

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L. Femoroplasty (CPT<sup>3</sup> 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) (CPT<sup>3</sup> 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 discectomy), 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.

P. Spinal manipulation under anesthesia (CPT<sup>3</sup> procedure codes 00640 and 22505) for the treatment of back pain 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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D. RFA for treatment of liver metastases from primary sites other than colorectal metastases is unproven (CPT<sup>3</sup> procedure codes 47370, 47380, and 47382).

E. Cytoreductive Surgery (CRS) and Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for treatment of Peritoneal Carcinomatosis (PC) from colorectal cancer.

V. EFFECTIVE DATES

A. 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.

B. 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.

C. TEM (CPT<sup>3</sup> procedure code 0184T) for treatment of benign lesions or malignant T1 tumors is covered effective June 2, 2009.

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CHAPTER 6, SECTION 1.1

GENERAL

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- Q. Thawing of cryopreserved, sperm/semen, each aliquot (CPT<sup>3</sup> procedure code 89353).
- R. Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT<sup>3</sup> procedure code 89354).
- S. Thawing of cryopreserved, oocytes, each aliquot (CPT<sup>3</sup> procedure code 89356).
- T. Allo Map<sup>®</sup> for molecular testing is unproven for use in cardiac transplant rejection surveillance.
- U. Oncotype Dx (S3854) is not covered due to the lack of U.S. Food and Drug Administration (FDA) status.
- V. OVA1<sup>™</sup> test for ovarian cancer.
- W. The Pathwork<sup>®</sup> Tissue of Origin Test is unproven to assist in identifying the origin of poorly differentiated, undifferentiated, or metastatic tumors.

V. EFFECTIVE DATE

July 23, 2008, for NMR LipoProfile-2 test, used with the NMR Profiler.

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IV. EXCLUSION

Cytoreductive Surgery (CRS) and Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for treatment of Peritoneal Carcinomatosis (PC) from colorectal cancer.

V. EFFECTIVE DATES

- A. October 25, 1999 for Paclitaxel (Taxol).
- B. January 7, 2005, for Paclitaxel protein-bound particles (Abraxane).

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