



TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
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**CHANGE 170  
6010.54-M  
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**REMOVE PAGE(S)**

**CHAPTER 1**

Section 3.1, pages 1 and 2

**CHAPTER 4**

Section 8.1, pages 1 and 2

Section 24.5, pages 1 through 4

**CHAPTER 5**

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Section 1.1, pages 7 and 8

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Section 1.1, pages 7 and 8

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Section 3.2, pages 1 and 2

pages 1, 2, 21, and 22

## **SUMMARY OF CHANGES**

### **CHAPTER 1**

1. Section 3.1. Proton Beam Therapy for the treatment of thymoma is unproven.

### **CHAPTER 4**

2. Section 8.1. Bronchial thermoplasty for the treatment of asthma is unproven.
3. Section 24.5. Liver Transplantation for the treatment of pediatric Ornithine Transcarbamylase Deficiency is considered safe and effective with an effective date of April 5, 2010.

### **CHAPTER 5**

4. Section 1.1. Magnetic Resonance Spectroscopy (MRS) of the brain is unproven.
5. Section 3.1.
  - a. Proton Beam Therapy for the treatment of thymoma is unproven.
  - b. Deletes brachytherapy and adds a cross reference to the reinserted brachytherapy/radiation therapy policy.
6. Section 3.2. Reinserts the policy issuance on Brachytherapy/Radiation Therapy and adds Electronic HDR Brachytherapy, as an adjunct to, or for the sole treatment of patients with breast cancer, as unproven.



## RARE DISEASES

ISSUE DATE: May 18, 1994

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

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### 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) (CPT<sup>1</sup> 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 (CPT<sup>1</sup> 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 (CPT<sup>1</sup> 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. EXCLUSIONS

A. Intracranial angioplasty with stenting (CPT<sup>1</sup> procedure code 61635) of the venous sinuses for treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension) is unproven.

B. Off-label use of rituximab for pediatric Immunoglobulin A (IgA) is unproven.

**C. Proton Beam Therapy (PBT)/radiosurgery/radiotherapy for the treatment of thymoma is unproven.**

- END -

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## RESPIRATORY SYSTEM

ISSUE DATE: August 26, 1985

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

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### I. CPT<sup>1</sup> PROCEDURE CODES

30000 - 32488, 32491, 32500 - 32999, 96570, 96571

### II. DESCRIPTION

The respiratory system is comprised of the tubular and cavernous organs and structures by means of which pulmonary ventilation and gas exchange between ambient air and the blood are brought about.

### III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the respiratory system are covered.

B. Resection of pneumatoceles is a covered procedure.

C. Lung Volume Reduction Surgery (LVRS) is a covered procedure, see [Chapter 4, Section 8.2](#).

D. Endoscopic thoracic sympathectomy (CPT<sup>1</sup> procedure code 32664) is covered for treatment of severe primary hyperhidrosis when appropriate nonsurgical therapies have failed and the hyperhidrosis results in significant functional impairment.

### IV. EXCLUSIONS

A. Pillar palatal implant system for the treatment of Obstructive Sleep Apnea (OSA) is unproven.

B. Uvulopalatopharyngoplasty (UPPP) (CPT<sup>1</sup> procedure code 42145) for the treatment of Upper Airway Resistance Syndrome (UARS) is unproven.

C. Nitric oxide expired gas determination (CPT<sup>1</sup> procedure code 95012) for asthma is unproven.

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CHAPTER 4, SECTION 8.1

RESPIRATORY SYSTEM

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D. Bronchial Thermoplasty (BT) (Healthcare Common Procedure Coding System (HCPCS) codes 0276T and 0277T) for the treatment of asthma is unproven.

V. EFFECTIVE DATE

December 1, 2006, for endoscopic thoracic sympathectomy for severe primary hyperhidrosis.

- END -

## LIVER TRANSPLANTATION

ISSUE DATE: September 3, 1986

AUTHORITY: [32 CFR 199.4\(e\)\(5\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODES

47133 - 47136, 47140 - 47142

### II. POLICY

A. Benefits are allowed for liver and living donor liver transplantations (LDLT).

1. A TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the contractor before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and contractor authorization, penalties will be administered according to TRICARE network provider agreements. If Prime enrollees receive health care services from non-network civilian providers without the required PCM referral and contractor authorization, MCS contractors shall reimburse charges for the services on a Point of Service basis. Special cost-sharing requirements apply to Point of Service claims.

2. For Standard and Extra patients residing in an MCS region, preauthorization is the responsibility of the MCS Medical Director or other designated utilization staff.

B. Liver and LDLT is covered when the transplantation is performed at a TRICARE or Medicare-certified liver transplantation center or TRICARE-certified pediatric consortium liver transplantation center for beneficiaries who:

1. Are suffering from irreversible hepatic disease; and
2. Have exhausted alternative medical and surgical treatments; and
3. Are approaching the terminal phase of their illness.
4. Demonstrate plans for a long-term adherence to a disciplined medical regimen are feasible and realistic.

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C. Liver and LDLT transplants performed for beneficiaries suffering from irreversible hepatic disease resulting from hepatitis B or C is covered.

D. Liver transplantation for severe classical Maple Syrup Urine Disease (MSUD) not controlled by dietary restriction may be considered on a case-by-case basis under the TRICARE provisions for the treatment of rare diseases.

E. Liver transplantation for the treatment of pediatric Ornithine Transcarbamylase Deficiency (OTCD) may be covered for this specific class of beneficiaries in accordance with the TRICARE provisions for the treatment of rare diseases.

F. Services and supplies related to liver and LDLTs are covered for:

1. Evaluation of a potential candidate's suitability for liver transplantation whether or not the patient is ultimately accepted as a candidate for transplantation.
2. Pre- and post-transplantation inpatient hospital and outpatient services.
3. Pre- and postoperative services of the transplantation team.
4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.
5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.
6. Donor costs.
7. Blood and blood products.
8. FDA approved immunosuppression drugs to include off-label uses when reliable evidence documents that the off-label use is safe, effective and in accordance with nationally accepted standards of practice in the medical community (proven).
9. Complications of the transplantation procedure, including inpatient care, management of infection and rejection episodes.
10. Periodic evaluation and assessment of the successfully transplanted patient.
11. Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.
12. DNA-HLA tissue typing determining histocompatibility.
13. Transportation of the patient by air ambulance and the services of a certified life support attendant.

III. POLICY CONSIDERATIONS

A. For beneficiaries who reside in TRICARE regions but fail to obtain preauthorization for liver or LDLT, benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the transplantation. TRICARE Prime enrollees who failed to obtain preauthorization will be reimbursed only under Point of Service rules.

B. Benefits will only be allowed for transplantations performed at a TRICARE or Medicare-certified liver transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a liver transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor in whose jurisdiction the center is located is the certifying authority for TRICARE authorization as a liver transplantation center. Refer to [Chapter 11, Section 7.1](#) for organ transplantation center certification requirements.

C. Liver transplantation will be paid under the DRG.

D. Claims for transportation of the donor organ and transplantation team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

E. Charges made by the donor hospital will be cost-shared on an inpatient basis and must be fully itemized and billed by the transplantation center in the name of the TRICARE patient.

F. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard CMS 1450 UB-04 claim form in the name of the TRICARE patient.

G. When a properly preauthorized transplantation candidate is discharged less than 24 hours after admission because of extenuating circumstances, such as the available organ is found not suitable or other circumstances which prohibit the transplantation from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

H. Liver or LDLT performed on an emergency basis in an unauthorized liver transplantation facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE or Medicare-certified liver transplantation center regarding the transplantation case;

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LIVER TRANSPLANTATION

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2. It must be determined and documented by the transplantation team physician(s) at the certified liver transplantation center that transfer of the patient (to the certified liver transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate; and

3. All other TRICARE contractual requirements have been met.

IV. EXCLUSIONS

A. Liver transplantation and LDLT is excluded when any of the following contraindications exist:

1. Significant systemic or multisystemic disease (other than hepatorenal failure) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

2. Active alcohol or other substance abuse that interferes with compliance to strict treatment regimen.

3. Malignancies metastasized to or extending beyond the margins of the liver.

B. The following are also excluded:

1. Expenses waived by the transplantation center (e.g., beneficiary/sponsor not financially liable).

2. Services and supplies not provided in accordance with applicable program criteria (i.e., part of a grant or research program; unproven procedure).

3. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off-label" drug indication.

4. Pre- or post-transplantation nonmedical expenses (e.g., out-of-hospital living expenses, to include hotel, meals, privately owned vehicle for the beneficiary or family members).

5. Transportation of an organ donor.

C. Artificial assist devices that are not FDA approved and that are not used in compliance with FDA approved indications.

V. EFFECTIVE DATES

A. November 1, 1994, for hepatitis C.

B. December 1, 1996, for hepatitis B.

C. April 5, 2010, for OTCD.

- END -



## RADIOLOGY

SECTION	SUBJECT
1.1	Diagnostic Radiology (Diagnostic Imaging)
2.1	Diagnostic Ultrasound
2.2	Radiologic Guidance
3.1	Radiation Oncology
3.2	Brachytherapy/Radiation Therapy
4.1	Nuclear Medicine
5.1	Thermography



E. 3D rendering (CPT<sup>7</sup> procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

F. 3D rendering (CPT<sup>7</sup> procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

G. 3D rendering (CPT<sup>7</sup> 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 (CPT<sup>7</sup> procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

I. CT angiography (CPT<sup>7</sup> 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 (CPT<sup>7</sup> 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) (CPT<sup>7</sup> 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) (CPT<sup>7</sup> 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.

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) (CPT<sup>7</sup> 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 (CPT<sup>7</sup> procedure code 0028T) is unproven.

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CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

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P. Computer-Aided Detection with breast MRI (CPT<sup>8</sup> procedure code 0159T) is unproven.

Q. Magnetic Resonance Spectroscopy (MRS), also known as NMR spectroscopy, of the brain 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 CPT<sup>8</sup> 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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## RADIATION ONCOLOGY

ISSUE DATE: March 27, 1991

AUTHORITY: 32 CFR 199.4(b)(2), (b)(2)(x), (c)(2)(viii), and (g)(15)

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### I. CPT<sup>1</sup> PROCEDURE CODES

61793, 61795, 77261 - 77421, 77427 - 77799, 0073T

### II. DESCRIPTION

A. Radiation therapy is also known as radiotherapy, radiation treatment, x-ray therapy, cobalt therapy, and proton beam therapy. The primary purpose of radiation therapy is to eliminate or shrink localized cancers (as opposed to cancers that have spread to distant parts of the body).

B. Stereotactic radiosurgery/radiotherapy is a method of delivering ionizing radiation to small intracranial targets. Stereotactic radiosurgery entails delivering a high dose in a single session. Stereotactic radiotherapy entails fractionating the dose over a number of treatments.

1. There are three main variations of stereotactic radiosurgery/radiotherapy: gamma beam or gamma knife, linear accelerator (linac), and charged particle beam (proton or helium ion). The three radiation delivery devices differ technically in several ways: source of radiation, size and shape of the radiation field, and range of radiation dosages.

2. The radiosurgical/radiotherapy procedure is preceded by a process of localizing the target, which can be performed with one or more of the following techniques: skull x-ray, cerebral angiography, Computerized Tomography (CT), or Magnetic Resonance Imaging (MRI).

### III. POLICY

A. Radiation therapy (fast neutron, hyperfractionated, and radioactive chromic phosphate synoviorthesis) is covered for those indications documented by reliable evidence as safe, effective and comparable or superior to standard care (proven). For coverage on brachytherapy/radiation therapy, see Chapter 5, Section 3.2.

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B. Hyperthermia is covered for those indications documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

C. Gamma knife 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. Arteriovenous malformations.
2. Benign brain tumors.
3. Acoustic neuromas (vestibular Schwannomas).
4. Pituitary adenomas.
5. Craniopharyngiomas.
6. Other tumors of the skull base.
7. Pineal region tumors.
8. Metastatic brain tumors.
9. High grade gliomas (glioblastoma multiforme, anaplastic astrocytomas).

D. Linear accelerator 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. Arteriovenous malformations.
2. Acoustic neuromas (vestibular Schwannomas).
3. Metastatic brain tumors.

E. Proton 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. Arteriovenous malformations.
2. Cushing's disease or acromegaly caused by pituitary microadenomas.
3. 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.

4. As primary therapy for patients with uveal melanoma, with no evidence of metastasis or extrascleral extension, and with tumors up to 22 mm in largest diameter and 14 mm in height.

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 (CPT<sup>2</sup> 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 (CPT<sup>2</sup> 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) (CPT<sup>2</sup> procedure code 77423) is unproven (except for treatment of adenoid cystic carcinoma, see [paragraph III.J.](#)).

**F. Proton Beam Therapy (PBT)/radiosurgery/radiotherapy for the treatment of thymoma is unproven.**

#### V. EFFECTIVE DATES

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

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RADIATION ONCOLOGY

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- 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 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 -



## BRACHYTHERAPY/RADIATION THERAPY

ISSUE DATE: March 27, 1991

AUTHORITY: 32 CFR 199.4(b)(2), (b)(2)(x), (c)(2)(viii), and (g)(15)

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### I. CPT<sup>1</sup> PROCEDURE CODES

19296, 19298, 77326 - 77328, 77750 - 77799, 79440

### II. DESCRIPTION

A. Brachytherapy is a type of radiation therapy in which the radiation source is placed within or very close to the body area being treated. Brachytherapy involves the use of radioactive isotopes as the radiation source, permanently or temporarily implanted, in the form of wires or seeds, into or near malignant tumors that are unresectable or recurrent following previous resection or radiotherapy. Commonly used radioisotopes include gold (198 Au), iodine (125 I), iridium (192 Ir), californium (252 Cf), cesium (137 Cs), and palladium (103 Pd).

B. Electronic brachytherapy is an alternative to radioactive brachytherapy. It can be delivered in one or multiple fractions. By definition, it is the delivery of brachytherapy (radiation directly on or into the target) with electronic systems rather than a radionuclide. Because of the low-energy x-ray source, the electronic brachytherapy use location is not limited to the shielded therapy suites necessary for linear accelerators and Iridium-192 High Dose Radiation (HDR) after-loading brachytherapy. The intended use of the electronic brachytherapy system is when a physician chooses to deliver intracavitary or interstitial radiation to the surgical margins after lumpectomy for breast cancer. However, the long-term safety and efficacy of the electronic brachytherapy procedure for the treatment of breast cancer have not been determined.

### III. POLICY

A. Benefits may be extended for brachytherapy.

B. Radioactive chromic phosphate synoviorthesis in the treatment of hemophilia patients with hemarthrosis and/or synovitis is covered when the medical record documents that more conservative therapies have failed. CPT<sup>1</sup> procedure codes that apply are:

1. 79440 (Intra-articular radionuclide therapy).

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2. 77750 (Infusion or instillation of radioelement).

C. Other brachytherapy techniques and devices (including medically necessary related supplies) are covered under the program only when it has received permission or approval for marketing by the U.S. Food and Drug Administration (FDA) and used according to the labeled indication on or after the day of FDA approval of the device (i.e., the MammoSite Brachytherapy System).

#### IV. POLICY CONSIDERATIONS

A. There are no categorical limitations on the use of brachytherapy, and indications and patient selection will vary as with any other form of radiotherapy.

B. Following is a list of conditions for which brachytherapy has been used. This list is not all-inclusive and should not be used as such:

1. Cervical, uterine, and prostate cancer.
2. Brain tumors, alone or combined with external beam radiation therapy.
3. Palliative treatment of bronchogenic carcinoma.
4. Adjuvant therapy of:

- Breast cancer.
- Renal cell carcinoma.
- Skin cancer.
- Head and neck cancer.
- Choroidal melanoma.
- Pancreatic carcinoma.
- Liver metastases.
- Bile duct carcinoma.
- Vaginal and vulvar carcinoma.
- Bladder carcinoma.
- Sacral chordoma.
- Childhood and adult sarcomas.
- Esophageal carcinoma.
- Retinoblastoma.
- Rectal carcinoma.

#### V. EXCLUSIONS

Brachytherapy, when administered through an high-dose-rate electronic brachytherapy system (i.e., Axxemt™ Electronic Brachytherapy System - CPT<sup>2</sup> procedure code 0182T), as an adjunct to, or for the sole treatment of patients with breast cancer is unproven.

- END -

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