



TRICARE
MANAGEMENT ACTIVITY

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**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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FOR
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CHANGE 174
6010.54-M
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REMOVE PAGE(S)

CHAPTER 1

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 3.1.
 - a. The off-label use of Selective Internal Radiation Therapy (SIRT) with 90Y microspheres (resin or glass) for the treatment of unresectable liver metastases from neuroendocrine tumors is safe and effective under the rare disease policy, and coverage may be granted to this specific class of beneficiaries. Effective Date is May 1, 2008.
 - b. Off label use of rituximab for the treatment of pediatric linear Immunoglobulin A (IgA) dermatosis is unproven and excluded from coverage.

CHAPTER 4

2. Section 6.1. Autologous Chondrocyte Implantation (ACI) surgery with Carticel™ for the repair of patellar cartilage lesions is unproven and is excluded from coverage.
3. Section 20.1. Allows coverage of a Vagus Nerve Stimulator as adjunctive therapy in reducing the frequency of seizures that are refractory to anti-epileptic medications in beneficiaries under the age of 12. Effective Date is July 27, 2012.

CHAPTER 5

4. Section 3.1.
 - a. Image-guided robotic linear accelerator-based stereotactic radiosurgery (CyberKnife) for the treatment of prostate cancer is unproven and excluded from coverage.
 - b. The off-label use of SIRT, also known as radioembolization, with 90Y microspheres (resin or glass) for the treatments of unresectable liver tumors from metastatic breast cancer is unproven and is excluded from coverage.

CHAPTER 7

5. Section 15.1. This change will update policy language to cover the Epley Canalith Repositioning Procedure under TRICARE Policy. Effective Date is June, 13, 2012.

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.

J. Off-label use of Selective Internal Radiation Therapy (SIRT) with yttrium-90 microspheres (resin or glass) may be considered for cost-sharing for the treatment of unresectable liver metastases from neuroendocrine tumors. The effective date is May 1, 2008. See [Chapter 5, Section 3.2](#) for policy regarding brachytherapy/radiation therapy.

III. EXCLUSIONS

A. 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.

B. The off-label use of rituximab for the treatment of pediatric linear Immunoglobulin A (IgA) dermatosis is unproven.

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

- END -

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

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 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 (CPT³ procedure codes 00640 and 22505) for the treatment of back pain is unproven.

Q. Minimally Invasive Lumbar Decompression (mild®) for the treatment of Degenerative Disc Disease (DDD) and/or spinal stenosis is unproven.

R. ACI surgery for the repair of patellar cartilage lesions 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.

- END -

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NERVOUS SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - ~~62264~~, ~~62268~~ - 62284, 62290 - 63048, 63055 - 64484, 64505 - 64560, 64565 - 64580, 64595, 64600 - 64650, 64680 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

II. DESCRIPTION

A. The nervous system consists of the central and peripheral nervous systems. The central is comprised of the brain and spinal cord and the peripheral includes all the other neural elements. The nervous system is the organ system which along with the endocrine system, correlates the adjustments and reactions of an organism to internal and environmental conditions.

B. Therapeutic embolization is a type of procedure that is commonly performed by interventional radiologist to occlude blood vessels. A microcatheter or balloon is threaded into a vein, or artery for the purposes of embolization, blocking a pathologic vascular channel.

C. Stereotactic implantation of depth electrodes is an invasive procedure in which needle-like electrodes are implanted through burr holes in the skull into the depths of specific brain areas to localize a seizure focus in patients who are candidates for surgery or to implant a brain stimulator in the thalamus to control tremors.

D. Psychosurgery is brain surgery directed at destroying normal and healthy brain tissue in order to relieve mental and psychic symptoms that other treatment modalities such as drug therapy and psychotherapy have been ineffectual in treating, for the purpose of changing or controlling behavior.

E. The Guglielmi Detachable Coil (GDC) is an extremely fine wire made from platinum, one of the softest metals, at the end of a longer stainless steel wire. In a controlled manner, the surgeon uses a micro-catheter to thread each coil through blood vessels to the aneurysm site. Application of a very-low-voltage electric current detaches and releases the coil into the aneurysm. Once in place, the GDC coils fill the aneurysm, isolating it from circulation to reduce the likelihood of rupture and hemorrhagic stroke. By applying a low voltage direct

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current to a stainless steel wire at the base of the coil, the platinum coil is detached. This applied current not only detaches the coil but also promotes electrothrombosis within the aneurysm.

III. POLICY

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

B. Therapeutic embolization (CPT² procedure code 61624) may be covered for the following indications. The 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. Cerebral Arteriovenous Malformations (AVMs).
2. Vein of Galen Aneurysm.
3. Inoperable or High-Risk Intracranial Aneurysms.
4. Dural Arteriovenous Fistulas.
5. Meningioma.

C. Implantation of depth electrodes is covered. Implantation of a U.S. Food and Drug Administration (FDA) approved vagus nerve stimulator, **and battery replacement**, may be covered for the following indications:

1. As adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age, which are refractory to anti-epileptic medication.
2. As therapy for children 12 years of age or younger who have a diagnosis of medically refractory Lennox-Gastaut Syndrome (LGS) (a rare disease).

3. Effective July 27, 2012, as adjunctive therapy in reducing the frequency of seizures that are refractory to anti-epileptic medications in beneficiaries under the age of 12.

D. Spinal cord and deep brain stimulation are covered in the treatment of chronic intractable pain. Coverage includes:

1. The accessories necessary for the effective functioning of the covered device.
2. Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

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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 (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.](#)).

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

G. Image-guided robotic linear accelerator-based stereotactic radiosurgery (CyberKnife®, Novalis Tx™, XKnife™, and Axesse™) for the treatment of prostate cancer is unproven.

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H. The off-label use of Selective Internal Radiation Therapy (SIRT), also known as radioembolization, with yttrium-90 microspheres (resin or glass) for the treatment of unresectable liver tumors from metastatic breast cancer is unproven and excluded from TRICARE coverage.

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 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 -

NEUROLOGY AND NEUROMUSCULAR SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: 32 CFR 199.4(b)(2)(vii) and (b)(3)(v)

I. CPT¹ PROCEDURE CODE RANGE

95812 - 95999

II. DESCRIPTION

The diagnosis and treatment of muscle and nerve disorders.

III. POLICY

A. Neurology and neuromuscular services are covered.

B. The Epley Canalith Repositioning Procedure (CRP) is covered for the treatment of Benign Paroxysmal Positional Vertigo (BPPV) with an effective date of June 13, 2012.

IV. EXCLUSIONS

A. Topographic brain mapping (brain electrical activity mapping, quantitative Electroencephalogram (EEG), digital EEG, topographic EEG, brain mapping EEG) is unproven.

B. 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, are unproven.

- END -

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