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**CHANGE 125
6010.57-M
JANUARY 6, 2015**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: EVOLVING PRACTICE 14-004

CONREQ: 17276

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: See page 3.

IMPLEMENTATION DATE: February 6, 2015.

**CORN.GLENN
.J.1157445967**

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CORN:GLENN.J.1157445967
DN: c=U.S, o=U.S. Government,
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Date: 20 14.12.31 08:05:38 -07'00'

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**ATTACHMENT(S): 9 PAGE(S)
DISTRIBUTION: 6010.57-M**

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**CHANGE 125
6010.57-M
JANUARY 6, 2015**

REMOVE PAGE(S)

CHAPTER 1

Section 3.1, pages 1 through 3

CHAPTER 4

Section 8.1, pages 1 and 2

Section 21.1, pages 1 and 2

CHAPTER 5

Section 3.2, pages 1 and 2

INSERT PAGE(S)

Section 3.1, pages 1 through 3

Section 8.1, pages 1 and 2

Section 21.1, pages 1 and 2

Section 3.2, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 1

1. Section 3.1. This change confirms that Laryngeal cleft has been found as a rare disease and Radiesse Voice injection laryngoplasty may be cost-shared as a treatment of type 1 laryngeal clefts.
EFFECTIVE DATE: 02/04/2011.

CHAPTER 4

2. Section 8.1. This change confirms that Radiofrequency Ablation of the tongue base to treat Obstructive Sleep Apnea is considered unproven. EFFECTIVE DATE: As indicated in the issuance.
3. Section 21.1. This change confirms that Visudyne Photodynamic Therapy is considered unproven. EFFECTIVE DATE: As indicated in the issuance.

CHAPTER 5

4. Section 3.2. This change confirms that Electronic Brachytherapy as unproven. EFFECTIVE DATE: As indicated in the issuance.

Rare Diseases

Issue Date: May 18, 1994

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

1.0 DESCRIPTION

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

2.0 POLICY

2.1 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.

2.1.1 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.

2.1.2 Trials published in refereed medical literature.

2.1.3 Formal technology assessments.

2.1.4 National medical policy organization positions.

2.1.5 National professional associations.

2.1.6 National expert opinion organizations.

2.2 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.

2.3 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.

2.4 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.

2.5 Effective May 13, 2009, Intraoperative Hyperthermic Chemotherapy (IPHC) (Current Procedural Terminology (CPT)¹ 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:

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

2.6 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.

2.7 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.

2.8 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.

2.9 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.

2.10 Radiofrequency Ablation (RFA), when performed using an U.S. Food and Drug Administration (FDA) approved electrosurgical cutting and coagulation device, may be considered for cost-sharing for the treatment of liver metastases from gastric cancer. The effective date is June 1, 2010.

2.11 Effective September 1, 2012, the NovoTTF-100A system (HCPCS A4555 and E0766) may be cost-shared for treatment of adult patients (22 years of age or older) with recurrent glioblastoma after surgical and radiation options have been exhausted.

2.12 Effective February 4, 2011, Radiesse® Voice laryngoplasty injections may be cost-shared for the treatment of type 1 laryngeal cleft (also described as supraglottic interarytenoid defects that extend no further than the true vocal folds).

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3.0 EXCLUSIONS

3.1 Intracranial angioplasty with stenting (CPT² procedure code 61635) of the venous sinuses for treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension) is unproven.

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

3.3 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\(c\)\(2\)](#)

1.0 CPT¹ PROCEDURE CODES

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

2.0 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.

3.0 POLICY

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

3.2 Resection of pneumatoceles is a covered procedure.

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

3.4 Endoscopic thoracic sympathectomy (CPT¹ 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.

4.0 EXCLUSIONS

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

4.2 Uvulopalatopharyngoplasty (UPPP) (CPT¹ procedure code 42145) for the treatment of Upper Airway Resistance Syndrome (UARS) is unproven).

4.3 Nitric oxide expired gas determination (CPT1 procedure code 95012) for asthma is unproven.

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

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TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 8.1

Respiratory System

4.5 Radiofrequency Ablation (RFA) of the tongue base to treat Obstructive Sleep Apnea (OSA) is unproven.

5.0 EFFECTIVE DATE

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

- END -

Eye And Ocular Adnexa

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#), [\(c\)\(3\)](#) and [\(g\)\(46\)](#)

1.0 CPT¹ PROCEDURE CODES

0192T, 65091 - 65755, 65772 - **66172, 66180** - 68899, 77600 - 77615

2.0 DESCRIPTION

The eye is the organ of vision and the ocular adnexa are the appendages or adjunct parts; i.e., eyelids, lacrimal apparatus.

3.0 POLICY

3.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the eye or ocular adnexa are covered.

3.2 Phototherapeutic Keratectomy (PTK) is covered for corneal dystrophies.

3.3 Strabismus. Surgical procedures and eye examinations to correct, treat, or diagnose strabismus are covered.

3.4 Corneal transplants. A corneal transplant (keratoplasty) is a covered surgical procedure. Relaxing keratotomy to relieve astigmatism following a corneal transplant is covered.

3.5 Transpupillary thermotherapy (laser hyperthermia, CPT¹ procedure codes 77600 - 77615), with chemotherapy, is covered for the treatment of retinoblastoma. See also [Chapter 5, Section 5.1](#).

3.6 Intrastromal Corneal Ring Segments (Intacs®) is covered for U.S. Food and Drug Administration (FDA) approved indications for beneficiaries with keratoconus who meet all of the following criteria: (1) are unable to achieve adequate vision using lenses or spectacles; and (2) for whom corneal transplant is the only remaining option. Coverage allowed effective July 17, 2005.

3.7 **Optional ExPRESS Mini glaucoma Shunt (CPT¹ procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.**

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4.0 EXCLUSIONS

4.1 Refractive corneal surgery except as noted in [paragraph 3.4](#) (CPT² procedure codes 65760, 65765, 65767, 65770, 65771).

4.2 Eyeglasses, and contact lenses except as noted in [Chapter 7, Section 6.2](#).

4.3 Orthokeratology.

4.4 Orthoptics, also known as visual training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT² procedure code 92065).

4.5 Epikeratophakia for treatment of aphakia and myopia is unproven.

4.6 Transpupillary thermotherapy (CPT² procedure code 67299) for treatment of choroidal melanoma is unproven.

4.7 Canaloplasty for the treatment of glaucoma (CPT² procedure codes 66174 and 66175).

4.8 Autologous serum eye drops for the treatment of dry eye syndrome, keratitis, or ocular hypertension is unproven.

4.9 Visudyne Photodynamic Therapy for Central Serous Retinopathy is considered unproven (CPT² procedure code 67221 and HCPCS J3396).

5.0 EFFECTIVE DATE

April 1, 2011, coverage for Optonal ExPRESS Mini Glaucoma Shunt.

- END -

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Brachytherapy/Radiation Therapy

Issue Date: March 27, 1991

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

1.0 CPT¹ PROCEDURE CODES

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

2.0 DESCRIPTION

2.1 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).

2.2 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 uses of high-dose-rate electronic brachytherapy are developing and expanding. However, the long-term safety and efficacy of the high-dose-rate electronic brachytherapy has not been determined.

3.0 POLICY

3.1 Benefits may be extended for brachytherapy.

3.2 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. CPT1 procedure codes that apply are:

- 79440 (Intra-articular radionuclide therapy).
- 77750 (Infusion or instillation of radioelement).

3.3 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

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indication on or after the day of FDA approval of the device (i.e., the MammoSite Brachytherapy System).

4.0 POLICY CONSIDERATIONS

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

4.2 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:

4.2.1 Cervical, uterine, and prostate cancer.

4.2.2 Brain tumors, alone or combined with external beam radiation therapy.

4.2.3 Palliative treatment of bronchogenic carcinoma.

4.2.4 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.

5.0 EXCLUSIONS

Brachytherapy, when administered through a high-dose-rate electronic brachytherapy system (CPT² procedure code 0182T), is unproven.

- END -

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