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SUMMARY OF CHANGES

CHAPTER 4

1. Section 20.1. Added CPT code range 64702 - 64719. Paragraph 3.24, added as an exclusion: Spinal cord and deep brain neurostimulation in the treatment of chronic intractable headache or migraine pain is unproven.

CHAPTER 6

2. Table of Contents. Deleted "And Counseling" from title of Section 3.1.
3. Section 3.1. Added clarification that genetic counseling shall be billed using the appropriate Evaluation and Management (E&M) codes. Added an exclusion for medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family (CPT code 96040).

CHAPTER 7

4. Section 16.2. Removed "by a clinical psychologist" to allow payment of health and behavior assessments by qualified mental providers. Deleted Exclusion 4.2 "Patient meeting criteria for a psychiatric diagnosis" to allow for a health and behavior assessment prior to establishment of a psychiatric diagnosis.

CHAPTER 8

5. Section 9.1. Clarified that legend vitamins may be cost-shared only when used as a specific treatment of a medical condition. Prenatal vitamins requiring a prescription in the United States may be cost-shared for prenatal care only.

CHAPTER 10

6. Section 6.1. Clarified eligibility for TRICARE for Life.

Nervous System

Issue Date: August 29, 1985

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

1.0 CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - 61860, 61863 - 63048, 63055 - 64484, 64505 - 64560, 64565 - 64580, 64600 - 64640, **64702 - 64719**, 64730, 64732 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

2.0 POLICY

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

2.2 Therapeutic embolization (CPT¹ 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).

- Cerebral Arteriovenous Malformations (AVMs).
- Vein of Galen Aneurysm.
- Inoperable or High-Risk Intracranial Aneurysms.
- Dural Arteriovenous Fistulas.
- Meningioma.
- Pulmonary Arteriovenous Malformations (PAVMs).

2.3 Implantation of depth electrodes is covered. Implantation of a U.S. Food and Drug Administration (FDA) approved vagus nerve stimulator 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 is covered. Battery replacement is also covered.

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

2.4.1 The accessories necessary for the effective functioning of the covered device.

2.4.2 Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

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2.5 The Guglielmi Detachable Coil (GDC) may be cost-shared for embolizing unruptured intracranial aneurysms that, because of their morphology, their location, or the patient's general medical condition, are considered by the treating neurosurgical team to be:

2.5.1 Very high risk for management by traditional operative techniques; or

2.5.2 Inoperable; or

2.5.3 For embolizing other vascular malformation such as AVMs and arteriovenous fistulae of the neurovasculature, to include arterial and venous embolizations in the peripheral vasculature.

3.0 EXCLUSIONS

3.1 N-butyl-2-cyanoacrylate (Histacryl Bleu®), iodinated poppy seed oils (e.g., Ethiodol®), and absorbable gelatin sponges are not FDA approved.

3.2 Transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders is unproven.

3.3 Deep brain neurostimulation in the treatment of insomnia, depression, anxiety, and substance abuse is unproven.

3.4 Psychosurgery is not in accordance with accepted professional medical standards and is not covered.

3.5 Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.

3.6 Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.

3.7 Dorsal Root Entry Zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

3.8 Epidural steroid injections for thoracic pain are unproven.

3.9 Extraoperative electrocortigraphy for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus is unproven.

3.10 Neuromuscular Electrical Stimulation (NMES) for the treatment of denervated muscles is unproven.

3.11 Stereotactic cingulotomy is unproven.

3.12 Sacral nerve neurostimulator (CPT² procedure codes 64561, 64581, 64585, and 64590). See [Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

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3.13 Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT³ procedure codes 63050 and 63051).

3.14 Balloon angioplasty, intracranial, percutaneous (CPT³ procedure code 61630) is unproven. Effective January 1, 2006.

3.15 Transcatheter placement of intravascular stent(s) intracranial, (e.g., atherosclerotic stenosis) including angioplasty, if performed (CPT³ procedure code 61635) is unproven. Effective January 1, 2006.

3.16 Balloon dilation of intracranial vasospasm, initial vessel (CPT³ procedure code 61640) each additional vessel in same family (CPT³ procedure code 61641) or different vascular family (CPT³ procedure code 61642) is unproven. Effective January 1, 2006.

3.17 Endoscopic thoracic sympathectomy.

3.18 Trigger point injection for migraine headaches.

3.19 Botox (chemodenervation), surgical denervation, and muscle resection for migraine headaches are unproven.

3.20 Sphenopalatine ganglion block (CPT³ procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

3.21 Radiofrequency ablation (percutaneous radiofrequency facet denervation, percutaneous facet coagulation, percutaneous radiofrequency neurotomy, radiofrequency facet rhizotomy, radiofrequency articular rhizolysis) (CPT³ procedure codes 64622, 64623, 64626, 64627) for the treatment of chronic spinal pain is unproven. Pulsed radiofrequency ablation for spinal pain is unproven.

3.22 Implantation of Occipital Nerve Stimulator for the treatment of chronic intractable migraine headache is unproven.

3.23 Cryoablation of Occipital Nerve (CPT³ procedure code 64640) for the treatment of chronic intractable headache is unproven.

3.24 Spinal cord and deep brain neurostimulation in the treatment of chronic intractable headache or migraine pain is unproven.

4.0 EFFECTIVE DATES

4.1 January 1, 1989, for PAVM.

4.2 April 1, 1994, for therapeutic embolization for treatment of meningioma.

4.3 July 14, 1997, for GDC.

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Chapter 4, Section 20.1

Nervous System

4.4 The date of FDA approval of the embolization device for all other embolization procedures.

4.5 June 1, 2004, for Magnetoencephalography.

- END -

Chapter 6

Pathology And Laboratory

Section/Addendum	Subject/Addendum Title
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1.1	General
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2.1	Transfusion Services For Whole Blood, Blood Components, And Blood Derivatives
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3.1	Diagnostic Genetic Testing
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Diagnostic Genetic Testing

Issue Date: March 10, 2000

Authority: [32 CFR 199.4\(a\)\(1\)\(i\)](#)

1.0 DESCRIPTION

Genetic testing intended to be confirmatory of a clinical diagnosis which is already suspected based on the patient's symptoms or risk status. Under the family planning benefit, genetic testing may also be performed in certain high risk individuals and pregnancies. For the purposes of the TRICARE benefit, genetic testing includes specific tests to detect developmental abnormalities as well as tests for specific genetic defects.

2.0 POLICY

2.1 Genetic counseling provided by an otherwise authorized provider is covered and must precede the actual diagnostic genetic testing.

2.2 Diagnostic genetic testing when medically proven and appropriate and when the results of the test will influence the medical management of the individual or pregnancy is a TRICARE benefit.

2.3 The following diagnostic tests are covered. This is not an all inclusive list, but provides examples of covered diagnostic tests.

2.3.1 Chromosome analysis (to include karyotyping and/or high resolution chromosome analysis) in some cases of habitual abortion or infertility.

2.3.2 Testing for Marfan Syndrome and chromosome analysis (to include karyotyping and/or high resolution chromosome analysis) of children. Common indications for chromosome analysis in children to include ambiguity of external genitalia, small-for-gestational age infants, multiple anomalies and failure to thrive.

2.3.3 Other medically necessary genetic diagnostic tests.

2.4 Genetic counseling services shall be billed using the appropriate Evaluation and Management (E&M) codes.

3.0 EXCLUSIONS

3.1 Routine genetic testing that does not influence the beneficiary's medical management.

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Chapter 6, Section 3.1

Diagnostic Genetic Testing

3.2 CPT¹ procedure code 96040 medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family.

- END -

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Health And Behavior Assessment/Intervention

Issue Date: March 11, 2002
Authority: [32 CFR 199.4\(a\)\(1\)](#)

1.0 CPT¹ PROCEDURE CODE RANGE

96150 - 96154

2.0 DESCRIPTION

Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatment.

3.0 POLICY

Health and behavior assessment performed in conjunction with the medical or surgical treatment of a covered illness or injury is covered.

4.0 EXCLUSION

Family evaluation and assessment (without the patient present) (CPT¹ procedure code 96155).

- END -

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Chapter 8, Section 9.1

Pharmacy Benefits Program

and also requires demonstrations from medical literature, national organizations, or technology assessment bodies that the unlabeled or off-label use of the drug is safe, effective, and in accordance with nationally accepted standards of practice in the medical community. As presented in order of relative weight in [32 CFR 199.2](#), reliable evidence means:

- Well controlled studies of clinical meaningful endpoints, published in refereed medical literature.
- Published formal technology assessments.
- Published reports of national professional medical associations.
- Published national medical policy organizations.
- Published reports of national expert opinion organizations.

2.2.6 Pharmaceutical agents grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be cost-shared as if FDA approved.

2.2.7 Insulin and related supplies may be cost-shared for known diabetic patients, even though a prescription may not be required for purchase.

2.2.8 Pharmaceutical agents with FDA "orphan drug" designation and marketing approval may be cost-shared when used in the treatment of a rare disease or condition. For the purpose of the Pharmacy Benefits Program, TRICARE adopts the FDA definition of the term "rare disease or condition."

2.2.9 Legend vitamins may be cost-shared only when used as a specific treatment of a medical condition. **In addition, prenatal vitamins that require a prescription in the United States may be cost-shared. Prenatal vitamins requiring a prescription are covered for prenatal care only.**

2.2.10 The DoD establishes quantity limits and prior authorizations for certain pharmaceutical agents. Prior authorization request forms, criteria, and list of pharmaceutical agents with established quantity limits are available at: http://www.tricare.mil/pharmacy/unif_form.cfm.

3.0 EXCLUSIONS

3.1 Pharmaceutical agents prescribed or furnished by a member of the patient's immediate family or a person living in the beneficiary's or sponsor's household.

3.2 Pharmaceutical agents, including compounded preparations, that are available over the counter.

3.3 Investigational pharmaceutical agents with FDA "Group C" designation have reproducible efficacy in one or more specific tumor types. Such a drug has altered or is likely to alter the pattern of treatment of the disease, and can be safely administered by properly trained physicians without specialized supportive care facilities. TRICARE may not cost-share use of Group C-designated pharmaceutical agents, because authorization for Group C distribution for a specific indication is not equivalent to formal FDA approval for that indication. Medical care related to the use of Group

C-designated pharmaceutical agents may be cost-shared only when the care would have been provided in the absence of the use of the Group C-designated drug.

3.4 Orphan pharmaceutical agents without marketing approval, but which are made available on a compassionate-use basis, may not be cost-shared.

3.5 Under the FDA treatment Investigational New Drug (IND) regulations enacted in 1987, pharmaceutical agents that are in controlled clinical trials can be provided outside those trials to treat patients with serious or immediately life-threatening diseases for which no comparable or satisfactory alternate therapy exists. TRICARE may not cost-share treatment INDs because they have not received FDA marketing approval. However, medical care related to the use of treatment INDs may be cost-shared when the patient's medical condition warrants their administration and the care is provided in accordance with generally accepted standards of medical practice.

3.6 Medical foods are not covered under the TPharm benefit. The term "medical food", as defined in section 5(b) of the Orphan Drug Act (21 USC § 360ee(b)(3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician, and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation."

3.7 Irinotecan (Camptosar®) for treatment of metastatic esophageal cancer is unproven.

4.0 UTILIZATION MANAGEMENT

4.1 Utilization management is the responsibility of the contractor with responsibility for the venue distributing the pharmaceuticals. Should another contractor require data about pharmaceutical prescribing practices of clinicians or the pharmaceuticals prescribed to a patient, the contractor requiring the information may submit a request for data to the Contracting Officer (CO). The requesting contractor shall commit to paying all costs associated with retrieving and providing any data. No contractor will be required to develop or provide data that are not available in the contractor's data warehouse.

4.2 The contractors shall screen prescription claims for potential over-utilization and substance abuse. If a potential drug abuse situation is identified by the MCSC, the pharmacy contractor, a private physician, a physician-reviewer in the course of business for the contractor, or a physician in a hospital setting, the beneficiary shall be placed on 100% prepayment review. The Government cannot cost share benefits to support or maintain potential drug abuse situations. This is true, whether or not the pharmaceutical agents are obtained by legal means, and are otherwise eligible for benefit consideration under other circumstances. The pharmacy contractor, in conjunction with the managed care support contractor or responsible military treatment facility shall:

4.2.1 Pend all claims for the beneficiary;

4.2.2 Establish the necessity for the pharmaceutical agents and their appropriateness based on diagnosis or definitive symptoms;

4.2.3 Deny all related claims if a drug abuse situation does exist, including office visits or emergency room visits if the purpose of the visit was to obtain pharmaceutical agents; and

Chapter 10

Section 6.1

TRICARE For Life (TFL)

Issue Date: September 25, 2001

Authority: 10 USC 1086(d)

1.0 DESCRIPTION

Medicare eligibles who are beneficiaries based on age and whose TRICARE eligibility is determined by 10 United States Code (USC) Section 1086, are eligible for Medicare Part A, and who are enrolled in Medicare Part B, are eligible for the TRICARE For Life (TFL) benefit. **Beneficiaries under age 65 who are also Medicare eligible, are also eligible for TFL (see the TRICARE Operations Manual (TOM), Chapter 20, Section 1, paragraphs 2.4 and 2.5).**

2.0 POLICY

2.1 Introduction

Section 712 extends TRICARE eligibility to persons who would otherwise have lost their TRICARE eligibility due to attainment of entitlement to hospital insurance benefits under Part A of Medicare based on age. In order for these individuals to retain their TRICARE eligibility, they must be enrolled in Part B of Medicare. In general, adjunctive dental care provided to these individuals for which payment may be made under both Medicare and TRICARE, Medicare is the primary payer and TRICARE will normally pay the actual out-of-pocket costs incurred by the person.

2.2 Eligibility

The contractors shall determine from the Defense Enrollment Eligibility Reporting System (DEERS) if the individual is eligible for TFL. TFL claims are processed in accordance with TRICARE Operations Manual (TOM), [Chapter 20](#).

2.3 Under certain conditions TFL beneficiaries may enroll in TRICARE Prime (see the TOM, Chapter 6, Section 1, paragraph 4.4).

2.4 Appeal rights are covered in the TOM, [Chapter 12](#).

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