



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 152
6010.54-M
FEBRUARY 15, 2012**

**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 - JANUARY 2012

CONREQ: 15845

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
Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 7 PAGE(S)
DISTRIBUTION: 6010.54-M

CHANGE 152
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REMOVE PAGE(S)

CHAPTER 4

Section 21.1, pages 1 and 2

CHAPTER 5

Section 4.1, pages 3 and 4

CHAPTER 7

Section 27.1, pages 1 - 3

INSERT PAGE(S)

Section 21.1, pages 1 and 2

Section 4.1, pages 3 and 4

Section 27.1, pages 1 - 3

SUMMARY OF CHANGES

CHAPTER 4

1. Section 21.1
 - a. Adds Canaloplasty for the treatment of glaucoma (CPT procedure codes 66174 and 66175) which remains unproven and is listed as an Exclusion.
 - b. Adds coverage for Optonal ExPress Mini Glaucoma Shunt (CPT procedure code 0192T) to reduce Intraocular Pressure (IOP) in the Treatment of Glaucoma, that cannot be controlled effectively with medications effective April, 1, 2011. Removes the exclusion for this treatment.

CHAPTER 5

2. Section 4.1, Under Exclusions, added PET for the diagnosis of renal mass or possible Renal Cell Carcinoma (RCC) recurrence is unproven.

CHAPTER 7

3. Section 27.1
 - a. Adds Botulinum toxin A (OnabotulinumtoxinA) injections for laryngeal dystonia (adductor spasmodic dysphonia) and oromandibular dystonia (jaw-closing dystonia) may be considered for cost-sharing.
 - b. Adds coverage for laryngeal dystonia (adductor spasmodic dysphonia) and oromandibular dystonia (jaw-closing dystonia) effective November 14, 1990. These two indications were inadvertently removed from the TPM.

EYE AND OCULAR ADNEXA

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

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

II. DESCRIPTION

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

III. POLICY

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

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

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

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

E. 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](#).

F. 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.

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G. Optonal ExPRESS Mini Glaucoma Shunt (CPT² procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.

IV. EXCLUSIONS

A. Refractive corneal surgery except as noted in paragraph III.D. (CPT² procedure codes 65760, 65765, 65767, 65770, 65771).

B. Eyeglasses, and contact lenses except as noted in Chapter 7, Section 6.2.

C. Orthokeratology.

D. 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).

E. Epikeratophakia for treatment of aphakia and myopia is unproven.

F. Transpupillary thermotherapy (CPT² procedure code 0016T) for treatment of coroidal melanoma is unproven.

G. Canaloplasty for the treatment of glaucoma (CPT² procedure code 66174 and 66175).

V. EFFECTIVE DATE

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

- END -

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D. Bone Density Studies (CPT² procedure codes 78350, 78351) are covered for:

1. The diagnosis and monitoring of osteoporosis.
2. The diagnosis and monitoring of osteopenia.

3. Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors which have been identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

a. Women who are estrogen-deficient and at a clinical risk of or osteoporosis. Naturally or surgically post-menopausal women who have not been on **long-term** Hormone Replacement Therapy (HRT). However, **current** use of HRT does not preclude estrogen deficiency.

b. Individuals who have vertebral abnormalities.

c. Individuals receiving long-term glucocorticoid (steroid) therapy.

d. Individuals with primary hyperparathyroidism.

e. Individuals with positive family history of osteoporosis.

f. Any other high-risk factor identified by ACOG as the standard of care.

IV. EXCLUSIONS

A. Bone density studies for the routine screening of osteoporosis.

B. PET for the diagnosis and monitoring of treatment of Alzheimer's disease, fronto-temporal dementia or other forms of dementia is unproven.

C. PET and PET/CT for the initial diagnosis of differentiated thyroid cancer and for medullary cell thyroid cancer.

D. Ultrasound ablation (destruction of **uterine** fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT² procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

E. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of gastric cancer is unproven.

F. PET and PET/CT for the initial diagnosis, staging, and monitoring of treatment of ovarian cancer is unproven.

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G. PET and PET/CT for the initial diagnosis and monitoring of treatment of colorectal cancer is unproven.

H. PET for the diagnosis of renal mass or possible Renal Cell Carcinoma (RCC) recurrence.

I. Scintimammography (HCPCS code S8080), Breast-Specific Gamma Imaging (BSGI) (CPT³ procedure codes 78800, 78801), and Molecular Breast Imaging (MBI) are unproven for all indications.

V. EFFECTIVE DATES

A. January 1, 1995, for PET for ischemic heart disease.

B. December 1, 1996, for PET for lung cancer.

C. October 14, 1990, for SPECT for myocardial perfusion imaging.

D. January 1, 1991, for SPECT for brain imaging.

E. October 28, 1996, for ¹¹¹In-Capromab Pendetide, CyT 356 (ProstaScint™).

F. June 1, 1994, for Octreoscan Scintigraphy.

G. May 26, 1994, for bone density studies.

H. January 1, 2007, for PET and PET/CT for lymphoma.

I. January 1, 2006, for PET and PET/CT for pancreatic cancer.

J. February 16, 2006, for PET and PET/CT for thyroid cancer.

K. December 1, 2008, for PET and PET/CT for ruling out recurrence of ovarian cancer.

L. May 1, 2007, for PET and PET/CT for staging, restaging, and detection of recurrence of colorectal cancer.

M. January 1, 2010, for PET/CT for metastatic bladder cancer.

- END -

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BOTULINUM TOXIN INJECTIONS

ISSUE DATE: October 12, 1998

AUTHORITY: 32 CFR 199.4(c)(2)(iii) and (c)(2)(iv)

I. CPT¹ PROCEDURE CODES

46505, 64612 - 64614, 64640, 64653, 67345

II. HCPCS PROCEDURE CODES

J0585, J0587

III. DESCRIPTION

These procedures involve the injection of small amounts of botulinum toxin into selected muscles for the nonsurgical treatment of the conditions relating to spasticity, various dystonias, nerve disorders, and muscular tonicity deviations.

IV. POLICY

A. Botulinum toxin A (**AbobotulinumtoxinA/OnabotulinumtoxinA**) and **Botulinum toxin B (RimabotulinumtoxinB)** injections may be considered for cost-sharing for treating conditions such as cervical dystonia (repetitive contraction of the neck muscles) in decreasing the severity of abnormal head position and neck pain for patients 16 years and older.

B. Botulinum toxin A (**OnabotulinumtoxinA**) injections may be considered for cost-sharing for treating conditions such as blepharospasm (spasm of the eyelids/uncontrolled blinking) and strabismus (squinting/eyes do not point in the same direction) associated with dystonia, including benign essential blepharospasm or VII nerve disorders for patients 12 years of age and older.

C. Botulinum toxin A (**OnabotulinumtoxinA**) injections may be considered for cost-sharing for treating conditions such as severe primary axillary hyperhidrosis (severe underarm sweating) that is inadequately managed by topical agents for patients 18 years of age and older.

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D. Botox® (OnabotulinumtoxinA-chemodenervation-CPT² procedure code 46505) may be considered for off-label cost-sharing for the treatment of chronic anal fissure unresponsive to conservative therapeutic measures, effective May 1, 2007.

E. Botulinum toxin A (AbobotulinumtoxinA/OnabotulinumtoxinA) injections may be considered for off-label cost-sharing for the treatment of spasticity resulting from Cerebral Palsy (CP), effective November 1, 2008.

F. Botox® (OnabotulinumtoxinA) and Myobloc® (RimabotulinumtoxinB) injections may be considered for off-label cost-sharing for the treatment of sialorrhea associated with Parkinson disease patients who are refractory to, or unable to tolerate, systemic anticholinergics, effective October 1, 2009.

G. Botulinum toxin A (OnabotulinumtoxinA) injections for prophylaxis of headaches in adult patients with chronic migraine, which is defined as 15 days or more per month with headache lasting four hours a day or longer.

H. Botulinum toxin A (OnabotulinumtoxinA) injections to treat spasticity in flexor muscles of the elbow, wrist, and fingers (upper limb spasticity) in adults.

I. Botulinum toxin A (OnabotulinumtoxinA) injections for laryngeal dystonia (adductor spasmodic dysphonia) and oromandibular dystonia (jaw-closing dystonia) may be considered for cost-sharing.

V. EXCLUSIONS

A. Botulinum toxin A injections are unproven for the following indications:

1. Palmar hyperhidrosis.
2. Urinary urge incontinence.
3. Lower back pain/lumbago.
4. Episodic migraine, chronic daily headache, cluster headache, cervicogenic headache, and tension-type headache.

B. Botox® (OnabotulinumtoxinA-chemodenervation-CPT² procedure code 64612) for the treatment of muscle spasms secondary to cervical degenerative disc disease and spinal column stenosis is unproven.

C. Botox® (OnabotulinumtoxinA) used for cosmetic indications (e.g., frown lines and brow furrows) is excluded from coverage.

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VI. EFFECTIVE DATES

A. May 1, 2007, for coverage of chronic anal fissure unresponsive to conservative therapeutic measures (CPT³ procedure code 46505).

B. October 1, 2009, for coverage of sialorrhea associated with Parkinson disease patients who are refractory to, or unable to tolerate systemic anticholinergics (CPT³ procedure code 64653).

C. October 15, 2010, coverage for prophylaxis of headaches in adult patients with chronic migraine, which is defined as 15 days or more per month with headache lasting four hours a day or longer.

D. March 9, 2010, coverage for spasticity in flexor muscles of the elbow, wrist, and fingers (upper limb spasticity) in adults.

E. November 14, 1990, coverage for laryngeal dystonia (adductor spasmodic dysphonia) and oromandibular dystonia (jaw-closing dystonia).

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