



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 93
6010.57-M
JULY 16, 2013**

**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: CONSOLIDATED CHANGE 13-002

CONREQ: 16476

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: Upon direction of the Contracting Officer.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TRM, Change No. 83.

**FAZZINI.ANN.NO
REEN.1199802271**

Digitally signed by
FAZZINI.ANN.NOREEN.1199802271
DN: c=US, o=U.S. Government, ou=DoD,
ou=PKI, ou=TMA,
cn=FAZZINI.ANN.NOREEN.1199802271
Date: 2013.07.10 12:24:52 -06'00'

**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 6 PAGE(S)
DISTRIBUTION: 6010.57-M**

CHANGE 93
6010.57-M
JULY 16, 2013

REMOVE PAGE(S)

CHAPTER 4

Section 23.1, pages 3 and 4

CHAPTER 7

Section 27.1, pages 1 - 3

CHAPTER 11

Section 3.2, pages 1 and 2

INSERT PAGE(S)

Section 23.1, pages 3 and 4

Section 27.1, pages 1 and 2

Section 3.2, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 4

1. Section 23.1. This change clarifies that covered lymphomas are either Hodgkin's disease or non-Hodgkin's disease.

CHAPTER 7

2. Section 27.1. This change clarifies the Botulinum Toxin Injections policy and inserts the reference to IncobotulinumtoxinA.

CHAPTER 11

3. Section 3.2. This change removes the reference to providers on probation.

TRICARE Policy Manual 6010.57-M, February 1, 2008
Chapter 4, Section 23.1
High Dose Chemotherapy (HDC) And Stem Cell Transplantation

3.2.2.3 The patient is in second or third complete remission.

3.2.3 Neuroblastoma.

3.2.3.1 Stage III or IV, when the patient is one for whom further treatment with a conventional dose therapy is not likely to achieve a durable remission.

3.2.3.2 Tandem autologous **PSCT** for high-risk neuroblastoma (INSS Stage III with either N-MYC gene amplification or unfavorable Shimada histology or INSS Stage IV).

3.2.4 Acute lymphocytic or nonlymphocytic leukemias (e.g., myelocytic, myelogenous, myeloblastic, or myelomonoblastic);

3.2.5 Primitive Neuroectodermal Tumors (PNET)/Ewing's Sarcoma.

3.2.6 Gliofibromas (also known as desmoplastic astrocytoma; desmoplastic glioblastoma).

3.2.7 Glioblastoma multiforme.

3.2.8 Posterior fossa teratoid brain tumors.

3.2.9 Rhabdomyosarcoma and undifferentiated sarcomas.

3.2.10 Multiple myeloma. Tandem autologous stem cell transplantation is covered for the treatment of multiple myeloma.

3.2.11 Chronic myelogenous leukemia.

3.2.12 Waldenstrom's macroglobulinemia.

3.2.13 AL (Amyloid Light-Chain) Amyloidosis.

3.2.14 Wilms' tumor.

3.2.15 Trilateral retinoblastoma/pineoblastoma.

3.2.16 Osteosarcoma (osteogenic sarcoma).

3.2.17 Germ cell tumors in a second or subsequent relapse.

3.2.18 HDC with ABMT or PSCT for the treatment of desmoplastic small round cell tumor may be considered on a case-by-case basis under the TRICARE provisions for treatment of rare diseases.

3.2.19 Immunoablative therapy with ABMT or autologous PSCT for the treatment of severe systemic lupus erythematosus refractory to conventional treatment.

3.3 Allogeneic **BMT** or allogeneic **PSCT**, with or without HDC, is covered in the treatment of the following disease processes when either a related or unrelated donor is used. 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).

3.3.1 Aplastic anemia.

3.3.2 Acute lymphocytic or nonlymphocytic leukemias (e.g., myelocytic, myelogenous, myeloblastic, myelomonoblastic); Chronic Myelogenous Leukemia (CML); or preleukemic syndromes.

3.3.3 Severe combined immunodeficiency; e.g., adenosine deaminase deficiency and idiopathic deficiencies.

3.3.3.1 Partially matched-related donor stem cell transportation (without regard for the number of mismatched antigens in determining histocompatibility) in the treatment of Bare Lymphocyte Syndrome.

3.3.3.2 Unrelated donor and/or related donor (without regard for mismatched antigens) with or without T cell lymphocyte depletion in the treatment of Familial Erythrophagocytic Lymphohistiocytosis, (FEL; generalized lymphohistiocytic infiltration; familial lymphohistiocytosis; familial reticuloendotheliosis; Familial Hemophagocytic Lymphohistiocytosis; FHL) for patients whose medical records document failure of conventional therapy (etoposide; corticosteroids; intrathecal methotrexate; and cranial irradiation).

3.3.3.3 Partially matched-related donor stem cell transplantation (without regard for the number of mismatched antigens) in the treatment of X-linked Severe Combined Immunodeficiency Syndrome (X-Linked SCID).

3.3.4 Wiskott-Aldrich Syndrome.

3.3.5 Infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease).

3.3.6 Thalassemia major.

3.3.7 Intermediate and high grade **non-Hodgkin's** lymphoma.

3.3.8 Myeloproliferative/dysplastic syndromes.

3.3.9 Congenital mucopolysaccharidoses.

3.3.10 Congenital amegakaryocytic thrombocytopenia.

3.3.11 Metachromatic leukodystrophy.

3.3.12 Sickle cell disease.

3.3.13 Chronic Lymphocytic Leukemia (CLL) when previous therapy has failed or when the CLL is refractory to conventional therapy.

3.3.14 Hyperesinophilic Syndrome.

Botulinum Toxin Injections

Issue Date: October 12, 1998

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

1.0 CPT¹ PROCEDURE CODES

46505, 64611 - 64614, 64640, 64653, 67345

2.0 HCPCS PROCEDURE CODES

J0585 - J0588

3.0 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.

4.0 POLICY

4.1 Botulinum toxin A (AbobotulinumtoxinA/OnabotulinumtoxinA/IncobotulinumtoxinA), Botulinum toxin B (RimabotulinumtoxinB), and any other Federal Drug Administration (FDA) approved botulinum toxin injectable drugs may be considered for cost-sharing for their FDA approved indications, unless otherwise excluded by the program.

4.2 Botox[®] (OnabotulinumtoxinA-chemodenervation-CPT¹ 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.

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

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

4.5 Botox[®] (OnabotulinumtoxinA) injections for laryngeal dystonia (adductor spasmodic dysphonia) and oromandibular dystonia (jaw-closing dystonia) may be considered for cost-sharing.

¹ CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

4.6 Off-label use. Effective July 27, 2012, off-label uses of Botulinum toxin A (AbobotulinumtoxinA/OnabotulinumtoxinA/IncobotulinumtoxinA), Botulinum toxin B (Rimabotulinumtoxin B), and any other FDA approved botulinum toxin injectable drugs may be approved for cost-sharing by the contractor in accordance with Chapter 8, Section 9.1, paragraph 2.2.5.

5.0 EXCLUSIONS

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

- Palmar hyperhidrosis.
- Lower back pain/lumbago.
- Episodic migraine, chronic daily headache, cluster headache, cervicogenic headache, and tension-type headache.

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

5.3 Botulinum toxin A used for cosmetic indications (e.g., frown lines and brow furrows) is excluded from coverage.

6.0 EFFECTIVE DATES

6.1 May 1, 2007, for coverage of chronic anal fissure unresponsive to conservative therapeutic measures (CPT² procedure code 46505).

6.2 October 1, 2009, for coverage of sialorrhea associated with Parkinson's disease patients who are refractory to, or unable to tolerate, systemic anticholinergics (CPT² procedure code 64653). Effective January 1, 2011, use CPT² procedure code 64611.

6.3 November 14, 1990, for coverage of laryngeal or oromandibular dystonia.

- END -

² CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

State Licensure And Certification

Issue Date: September 20, 1990

Authority: [32 CFR 199.6\(c\)\(2\)\(i\)](#) and [\(c\)\(2\)\(ii\)](#)

1.0 ISSUE

TRICARE requirement for state licensure and certification.

2.0 POLICY

2.1 State Licensure/Certification. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the state where the service is rendered. Licensure/certification in a profession other than that for which the provider is seeking authorization is not acceptable. The licensure/certification must be at the full clinical level of practice. Full clinical practice level is defined as an unrestricted license that is not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction. The services provided must be within the scope of the license, certification, or other legal authorization. Licensure or certification is required to be an authorized provider when offered in the state where the service is rendered, even if such licensure or certification is not required by the state where the service is rendered. Providers who practice in a state where licensure or certification is optional are required to obtain that licensure or certification to become an authorized provider. A temporary professional state license which allows full and unrestricted scope of practice fully satisfies any Individual Professional Provider certification requirement for the period during which the temporary license is valid. The authorized status of the provider expires when the temporary license expires unless the temporary license is renewed or a regular license is issued to the provider.

2.2 Certified Membership in National or Professional Association that Sets Standards for the Profession. If the state does not offer licensure or certification, the provider must have membership in or certification by (or be eligible to have membership in or certification by) the appropriate national or professional association that sets standards for the specific profession. Associate, provisional, or student membership is not acceptable. Membership or certification must be at the full clinical level. If the provider does not have membership in or certification by the standard setting national or professional association, acceptable proof of eligibility is a letter or other written documentation from the appropriate association stating that the provider meets the requirements to be a member of or certified by the association.

2.3 Time Period for Obtaining Licensure or Certification. When a new State law is enacted that requires or provides for a certain category of provider to be in possession of licensure or

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 11, Section 3.2

State Licensure And Certification

certification, authorized providers must obtain the license as soon as the State begins issuance. A period of time, not to exceed a maximum of six months, will be authorized to obtain the license.

- END -