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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 127
6010.54-M
AUGUST 9, 2010**

**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: CODING AND CLARIFICATION UPDATES APRIL 2010

CONREQ: 15020

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.

This change is made in conjunction with Aug 2002 TOM, Change No. 99, and Aug 2002 TRM, Change No. 118.

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Reimbursement Branch**

**ATTACHMENT(S): 15 PAGE(S)
DISTRIBUTION: 6010.54-M**

CHANGE 127
6010.54-M
AUGUST 9, 2010

REMOVE PAGE(S)

CHAPTER 1

Section 1.1, page 7

CHAPTER 4

Section 5.1, pages 1 and 2

Section 5.2, pages 1 and 2

Section 5.3, pages 1 and 2

Section 5.8, pages 1 - 3

Section 20.1, pages 1 and 2

CHAPTER 7

Section 7.1, pages 1 and 2

INSERT PAGE(S)

Section 1.1, page 7

Section 5.1, pages 1 and 2

Section 5.2, pages 1 and 2

Section 5.3, pages 1 and 2

Section 5.8, pages 1 - 4

Section 20.1, pages 1 and 2

Section 7.1, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 1

1. Section 1.1. Repositioned the word "institutionalized".

CHAPTER 4

2. Section 5.1. Deleted all paragraphs/text related to AlloDerm and moved them to Chapter 4, Section 5.2, paragraph IV.H.
3. Section 5.2. Added HCPCS Code Q4116. Added AlloDerm related text.
4. Section 5.3. Paragraphs clarified coverage for bilateral prophylactic mastectomies when there is a history of breast cancer in multiple first-degree relatives and/or multiple successive generations of family members with breast and/or ovarian cancer (Family Cancer Syndrome). A positive genetic test is not necessary.
5. Section 5.8. Addressed contraindications and patient risk factors associated with Negative Pressure Wound Therapy (NPWT).
6. Section 20.1. Updated the list of CPT procedure codes.

CHAPTER 7

7. Section 7.1. Clarified speech - language pathology services that are eligible for coverage.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 1, SECTION 1.1

EXCLUSIONS

61. Housekeeping, homemaker, or attendant services, sitter or companion (for exceptions, see [32 CFR 199.4\(e\)\(19\)](#) regarding hospice care) (see the TRICARE Reimbursement Manual (TRM), [Chapter 11, Sections 1 and 4.](#)).

62. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

63. Personal, comfort, or convenience items, such as beauty and barber services, radio, television, and telephone (for exceptions, see [32 CFR 199.4\(e\)\(19\)](#) regarding hospice care).

NOTE: Admission kits are covered.

64. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

65. All transportation except by ambulance, as specifically provided under [32 CFR 199.4\(d\)](#) and [\(e\)\(5\)](#).

NOTE: Transportation of an **institutionalized** ECHO beneficiary to or from a facility or institution to receive authorized ECHO services or items may be cost-shared under [32 CFR 199.5\(c\)\(6\)](#). Transportation of an accompanying medical attendant to ensure the safe transport of the ECHO beneficiary may also be cost-shared (see [Chapter 9, Section 11.1](#)).

66. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in [32 CFR 199.4\(a\)\(6\)](#).

NOTE: For the exception for certain Prime travel expenses and non-medical attendants, see [32 CFR 199.17\(n\)\(2\)\(vi\)](#) and the TRM, [Chapter 1, Section 30](#).

67. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by TRICARE. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities.

68. Service animals (Seeing Eye dogs, hearing/handicap assistance dogs, seizure and other detection animals, service monkeys, etc.) are excluded from coverage under the Basic or ECHO programs.

- END -

INTEGUMENTARY SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

10021, 10022, 10040 - 11977, 11981 - 11983, 12001 - 15366, 15400 - 15431, 15570 - 15776, 15840 - 15845, 15851 - 19499, 97601, and 97602

II. DESCRIPTION

Integumentary system pertains to the skin, subcutaneous tissue and areolar tissue.

III. POLICY

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

B. Topical Treatment of Skin Ulcers Caused by Venous Insufficiency. Topical application of Alpigraf by a physician for the treatment of skin ulcers caused by venous insufficiency is a covered benefit. Effective May 26, 1998.

C. Tropical Treatment of Diabetic Foot Ulcers. Application of tissue cultured skin grafts for diabetic foot ulcers is a covered benefit. Effective May 8, 2000.

D. Topical Treatment of Diabetic Foot Ulcers. Application of Becaplermine Gel (Regranex) is a covered treatment of lower extremity diabetic neuropathic foot ulcers that extend into the subcutaneous tissue or beyond. Effective December 16, 1997.

E. Negative Pressure Wound Therapy (NPWT) may be covered effective November 9, 2007 when certain criteria are met. See [Section 5.8](#).

IV. EXCLUSIONS

A. Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

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CHAPTER 4, SECTION 5.1

INTEGUMENTARY SYSTEM

B. Services performed for cosmetic purposes.

C. Subcutaneous hormone (estradiol and/or testosterone) pellet implantation (CPT² procedure code 11980) is unproven. Estradiol pellets are not U.S. Food and Drug Administration (FDA) approved for general use in humans.

- END -

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POSTMASTECTOMY RECONSTRUCTIVE BREAST SURGERY

ISSUE DATE: October 7, 1982

AUTHORITY: [32 CFR 199.4\(e\)\(8\)\(i\)\(D\)](#)

I. CPT¹ PROCEDURE CODES

19160 - 19240, 19340 - 19499 (For post-mastectomy reconstruction surgery)
19316, 19318, 19324 - 19325 (For contralateral symmetry surgery)

II. HCPCS CODES

Q4116 (AlloDerm®)

III. DESCRIPTION

Breast reconstruction consists of both mound reconstruction, nipple-areola reconstruction and areolar/nipple tattooing.

IV. POLICY

A. Payment may be made for post-mastectomy reconstruction of the breast following a covered mastectomy.

B. Payment may be made for contralateral symmetry surgery (i.e., reduction mammoplasty, augmentation mammoplasty, or mastopexy performed on the other breast to bring it into symmetry with the post-mastectomy reconstructed breast).

NOTE: Services related to the reduction of the contralateral breast in post-mastectomy reconstructive breast surgery are not subject to the regulatory exclusion for mammoplasties performed primarily for reasons of cosmesis.

C. Treatment of complications following reconstruction (including implant removal) regardless of when the reconstruction was performed, and complications that may result following symmetry surgery, removal and reinsertion of implants are covered.

D. External surgical garments (specifically designed as an integral part of an external prosthesis) are considered medical supply items and are covered in lieu of reconstructive breast surgery.

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CHAPTER 4, SECTION 5.2

POSTMASTECTOMY RECONSTRUCTIVE BREAST SURGERY

NOTE: Benefits are subject to two initial mastectomy bras and two replacement mastectomy bras per calendar year.

E. Breast prosthesis is limited to the first initial device per missing body part. Requests for replacements are subject to medical review to determine reason for replacement.

F. U.S. Food and Drug Administration (FDA) approved implant material and customized external breast prostheses are covered.

G. Breast Magnetic Resonance Imaging (MRI) to detect implant rupture is covered. The implantation of the breast implants must have been covered by TRICARE.

H. AlloDerm® (an acellular allograft) is a covered benefit, effective July 8, 2008, when used in a covered breast reconstruction surgery for women who have any of the following indications:

1. Have insufficient tissue expander or implant coverage by the pectoralis major muscle and additional coverage is required; or

2. There is viable, but compromised or thin post-mastectomy skin flaps that are at risk of dehiscence or necrosis; or

3. The infra-mammary fold and lateral mammary folds have been undermined during mastectomy and re-establishment of these landmarks are needed.

- END -

PROPHYLACTIC MASTECTOMY, PROPHYLACTIC OOPHORECTOMY, AND PROPHYLACTIC HYSTERECTOMY

ISSUE DATE: October 25, 1993

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

I. CPT¹ PROCEDURE CODES

19300 - 19307, 58150 - 58294, 58541 - 58554, 58661, 58720, 58940 - 58956

II. DESCRIPTION

A. Prophylactic mastectomy is an extirpative procedure (usually simple or total mastectomy) which removes all breast tissue which would be otherwise subject to breast carcinoma. Carefully selected indications have been developed for prophylactic mastectomy and are included in this policy.

B. Prophylactic oophorectomy is removal of the ovaries before development of cancerous cells. Carefully selected indications have been developed for prophylactic oophorectomy and are included in this policy.

C. Prophylactic hysterectomy is removal of the uterus before development of cancerous cells. Carefully selected indications have been developed for prophylactic hysterectomy and are included in this policy.

III. POLICY

A. Bilateral prophylactic mastectomies are covered for patients at increased risk of developing breast carcinoma who have one or more of the following:

1. Atypical hyperplasia of lobular or ductal origin confirmed on biopsy; or
2. A **history of breast cancer in multiple first-degree relatives and/or multiple successive generations of family members with breast and/or ovarian cancer (Family Cancer Syndrome). A positive Breast Cancer (BRCA) genetic test is not necessary;** or
3. Fibronodular, dense breasts which are mammographically and/or clinically difficult to evaluate and the patient presents with either of the above (or both) clinical presentations.

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B. Unilateral prophylactic mastectomies are covered when the contralateral breast has been diagnosed with cancer for patients with:

1. Diffuse microcalcifications in the remaining breast, especially when ductal in-situ carcinoma has been diagnosed in the contralateral breast; or
2. Lobular carcinoma in-situ; or
3. Large breast and/or ptotic, dense or disproportionately-sized breast that are difficult to evaluate mammographically and clinically; or
4. In whom observational surveillance is elected for lobular carcinoma in-situ and the patient develops either invasive lobular or ductal carcinoma; or
5. A **history of breast cancer in multiple first-degree relatives and/or multiple successive generations of family members with breast and/or ovarian cancer** (Family Cancer Syndrome). **A positive BRCA genetic test is not necessary.**

C. Prophylactic oophorectomy is covered for women who meet any of the following criteria:

1. Women who have been diagnosed with an hereditary ovarian cancer syndrome based on a family pedigree constructed by an authorized provider competent in determining the presence of an autosomal dominant inheritance pattern; or
2. Women with a personal history of steroid hormone receptor-positive breast cancer; or
3. Women with a personal history of breast cancer and at least one first degree relative (mother, sister, daughter) with a history of ovarian cancer; or
4. Women who have two or more first degree relatives with a history of breast or ovarian cancer; or
5. Women with one first degree relative and one or more second degree relative (grandmother, aunt, or niece) with ovarian cancer.
6. Some families have pedigrees that are very small, and therefore have only one first degree relative with ovarian cancer or young-onset breast, colon, or endometrial cancer that may suggest increased risk for ovarian cancer. These individuals may also be considered for prophylactic oophorectomy. Effective January 1, 2006.

D. Prophylactic hysterectomy is covered:

1. For women who are about to undergo or are undergoing tamoxifen therapy.
2. For women who have been diagnosed with Hereditary **Non-polyposis** Colorectal Cancer (HNPCC) or are found to be carriers of HNPCC-associated mutations.

NEGATIVE PRESSURE WOUND THERAPY (NPWT)

ISSUE DATE: December 15, 2009

AUTHORITY: 32 CFR 199.4(c)(2), (c)(3), and (e)(21)(ii)

I. CPT¹ PROCEDURE CODES

11000 - 11044, 97597 - 97606

II. HCPCS CODES

A6550, A7000, E2402

III. DESCRIPTION

Negative Pressure Wound Therapy (NPWT) applies a localized vacuum to draw the edges of an open wound together while providing a moist environment conducive to rapid wound healing. NPWT is also known as Topical Negative Pressure (TNP) and Vacuum-Assisted Closure (VAC). The goal of NPWT is to create a controlled, closed wound amenable to surgical closure, grafting, or healing by secondary intention. An evacuation tube is embedded in a dressing made of foam. After thorough wound debridement, the foam dressing is placed within the wound bed and covered by a dressing to form an airtight seal, and the tube is attached to a vacuum unit. Continuous or intermittent negative pressure is applied. The amount of pressure is determined by the wound type. NPWT is designed to result in: (1) removal of excess fluid; (2) increased blood flow and decreased bacterial colonization; (3) granulation tissue formation; and (4) partial or complete wound closure with or without the need for additional procedures.

IV. POLICY

A. A NPWT pump and supplies are covered when one of the following conditions exists:

1. Complications of surgically created wound (e.g., dehiscence, poststernotomy disunion with exposed sternal bone, poststernotomy mediastinitis, or postoperative disunion of the abdominal wall).
2. Traumatic wound (e.g., preoperative flap or graft, exposed bones, tendons, or vessels) and a need for accelerated formation of granulation tissue not achievable by other

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topical wound treatments (e.g., the individual has comorbidities that will not allow for healing times usually achievable with other available topical wound treatments).

3. Chronic nonhealing Stage III or IV pressure ulcer, diabetic neuropathic ulcer or chronic venous ulcer with lack of improvement for at least the previous 30 days despite standard wound therapy, including the application of moist topical dressings, debridement of necrotic tissue (if present), maintenance of an adequate nutritional status, and weekly evaluations with documentation of wound measurements (i.e., length, width, and depth).

B. NPWT is covered:

1. Only after careful consideration has been given to the following risk factors:

a. Patients with friable vessels and infected blood vessels, sharp edges in the wound (i.e., bone fragments), or Spinal Cord Injury (SCI) (stimulation of sympathetic nervous system);

b. Patients requiring Magnetic Resonance Imaging (MRI), hyperbaric chamber, defibrillation;

c. Patient size and weight;

d. Use near vagus nerve (bradycardia);

e. Circumferential dressing application;

f. Mode of therapy-intermittent versus continuous negative pressure.

2. For a period of up to four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) in the treatment of any wound. The medical necessity of NPWT beyond four months will be given individual consideration based upon required additional documentation including but not limited to:

a. Documentation of progression of healing of the wound on two successive dressing changes, as determined by quantitative measurements of wound characteristics including wound length and width (surface area), or depth, serially observed and documented; and

b. Documentation of appropriate medical professional supervision or performance of weekly wound measurement and assessment functions as well as the negative pressure wound therapy dressing changes required; or

3. In the judgment of the treatment physician, until adequate wound healing has occurred to the degree that NPWT may be discontinued; or

4. Until equipment or supplies are no longer being used for the patient, whether or not by the physician's order.

C. When the patient is monitored frequently in an appropriate care setting by a licensed health care professional. Frequency of monitoring shall be determined by the patient's condition, wound status, wound location, and co-morbidities.

D. When the patient is determined to be a proper candidate for using the NPWT system at home, a licensed health care professional will ensure the patient receives appropriate training prior to using the NPWT system to include:

1. Demonstration and documentation of the patient's proficiency in using the system;

2. Potential complications and their signs and symptoms, and what to do if complications occur;

3. Ensuring patient understanding of the warnings associated with NPWT system use; and

4. Providing patient with a written copy of the patient labeling from the NPWT manufacturer, if available.

E. A licensed health care professional, for the purposes of this policy, may be a physician, Physician's Assistant (PA), Registered Nurse (RN), Licensed Practical Nurse (LPN), or Physical Therapist (PT). The practitioner should be licensed to assess wounds and/or administer wound care within the state where the beneficiary is receiving NPWT.

F. NPWT devices must be FDA approved.

V. EXCLUSION

A. An NPWT pump and supplies are excluded under any of the following conditions:

1. For patients whose wounds respond to standard therapeutic measures.

2. The patient cannot tolerate the use of NPWT.

3. For patients with the following contraindications:

a. Active bleeding;

b. Anticoagulant use;

c. Difficult wound hemostasis;

d. Exposed organs;

e. Exposed vasculature;

f. Exposed nerves;

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CHAPTER 4, SECTION 5.8

NEGATIVE PRESSURE WOUND THERAPY (NPWT)

g. Exposed anastomotic site;

h. Inadequately debrided wounds;

i. Untreated osteomyelitis;

j. Necrotic tissue with eschar present;

k. Infection in the wound;

l. Malignancy in the wound; and

m. Non-enteric and unexplored fistulas.

4. Uniform granulation tissue has been obtained.

5. The depth of the wound is less than one mm, as wounds of this depth cannot accommodate the sponge.

VI. EFFECTIVE DATE

November 9, 2007.

- END -

NERVOUS SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2) and (c)(3)

I. CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - 61860, 61863 - 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 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.

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.

E. The 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:

1. Very high risk for management by traditional operative techniques; or
2. Inoperable; or

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SPEECH SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.6\(c\)](#), and Public Law 107-107

I. CPT¹ PROCEDURE CODES

92506 - 92508, 92630 - 92633

II. DESCRIPTION

Speech-language pathology services that provide evaluation, treatment, habilitation, and rehabilitation of **communication disorders** resulting from congenital anomalies, disease, injury, hearing loss, pervasive developmental disorders or a therapeutic process, **or other condition, such as pragmatic language impairment, that prevents or diminishes an individual's ability to communicate.**

III. POLICY

A. **Speech-language pathology** services provided or prescribed and supervised by a physician may be cost-shared.

B. **Speech-language pathology services** to improve, restore, or maintain function, or to minimize or prevent deterioration of function of a patient when prescribed by a physician is covered in accordance with the rehabilitative therapy provisions found in [Chapter 7, Section 18.1](#).

IV. EXCLUSIONS

A. Services provided to address speech, language, or communication disorders resulting from occupational or educational deficits.

B. For beneficiaries under the age of **three**, services and items provided in accordance with the beneficiary's Individualized Family Service Plan as required by Part C of the Individuals with Disabilities Education Act, and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

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CHAPTER 7, SECTION 7.1

SPEECH SERVICES

C. For beneficiaries ages **three** to 21 who are receiving special education services from a public educational agency, cost-sharing of outpatient speech services that are required by the **IDEA** and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of speech services as proposed by the educational agency are not appropriate medical care.

D. Myofunctional or tongue thrust therapy.

E. Maintenance therapy that does not require a skilled level after a therapy program has been designed (see [Chapter 7, Section 18.1](#)).

F. Videofluoroscopy evaluation in speech pathology.

G. Speech therapists (speech pathologists) are not authorized to bill using Evaluation and Management (E&M) codes listed in the Physicians' Current Procedural Terminology (CPT).

- END -