

## CARDIOVASCULAR SYSTEM

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### I. CPT<sup>1</sup> PROCEDURE CODES

33010 - 33130, 33140, 33141, 33200 - 34834, 35001 - 37799, 92950 - 93572, 93580 - 93744, 93770, 93797 - 93799

### II. DESCRIPTION

The cardiovascular system involves the heart and blood vessels, by which blood is pumped and circulated through the body.

### III. POLICY

A. Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the cardiovascular system are covered.

B. Ventricular assist devices (external and implantable) are covered if the device is FDA approved and used in accordance with FDA approved indications.

C. Gamma and beta intracoronary radiotherapy (brachytherapy) is covered for the treatment of in-stent restenosis in native coronary arteries.

D. Transmyocardial revascularization (TMR) (CPT<sup>1</sup> procedures codes 33140 and 33141).

1. Coverage is available for patients with stable class III or IV angina which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages. In addition, the angina symptoms must be caused by areas of the heart not amenable to surgical therapies such as percutaneous transluminal coronary angioplasty, stenting, coronary atherectomy or coronary bypass.

2. Coverage is limited to those uses of the laser used in performing the procedure which have been approved by the FDA for the purpose for which they are being used.

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E. TMR as an adjunct to CABG is covered for patients with documented areas of the myocardium that are not amenable to surgical revascularization due to unsuitable anatomy.

IV. EXCLUSIONS

A. Thermogram; cephalic (CPT<sup>2</sup> procedure code 93760); peripheral (CPT<sup>2</sup> procedure code 93762) are unproven.

B. Ambulatory blood pressure monitoring is unproven.

93784 - AMBULATORY BP MONITORING<sup>2</sup>

93786 - AMBULATORY BP RECORDING<sup>2</sup>

93788 - AMBULATORY BP ANALYSIS<sup>2</sup>

93790 - REVIEW/REPORT BP RECORDING<sup>2</sup>

C. Percutaneous Myocardial Laser Revascularization (PMR) is unproven.

D. Cardiomyoplasty (Cardiac Wrap) for treatment of heart failure is unproven.

E. Minimally Invasive Coronary Artery Bypass Graft (CABG) surgery to include Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) and Port Access Coronary Artery Bypass (PACAB) are unproven.

F. Percutaneous Transluminal Angioplasty (PTA) in the treatment of obstructive lesions of the carotid, vertebral and cerebral arteries is unproven.

G. Signal-Average Electrocardiography (CPT<sup>2</sup> procedure code 93278) is unproven.

V. EFFECTIVE DATES

A. March 1, 2001, for gamma and beta intracoronary radiotherapy (brachytherapy).

B. January 1, 2002, for TMR.

- END -

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