



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 55
6010.54-M
JANUARY 30, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.54-M, issued August 2002.

CHANGE TITLE: 2006 HCPCS/CPT UPDATES UNPROVEN

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): TRICARE Policy Manual changes for 2006 CPT
updates unproven.

EFFECTIVE DATE: January 1, 2006

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

A handwritten signature in black ink, appearing to read "Reta Michak".

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 24 PAGE(S)
DISTRIBUTION: 6010.54-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

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APPENDIX A

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SUMMARY OF CHANGES

The 2006 CPT Annual Update identifies the new 2006 coding changes made by the American Medical Association (AMA) Current Procedural Terminology (CPT) for physicians and qualified non-physician practitioners.

CHAPTER 4

1. Section 1.1A (Category III Codes) 0001T, 0003T - 0024T, 0026T - 0088T.

Added new Category III codes 0089T - 0161T to code range. The following Category II codes were deleted effective January 1, 2006 (see assigned Category I codes): 0001T, 0002T, 0005T - 0007T, 0009T, 0012T - 0014T, 0018T, 0020T, 0023T, 0025T, 0033T - 0040T. New CPT procedure code range is 0003T, 0008T, 0016T - 0019T, 0021T, 0024T, 0026T - 0032T, and 0041T - 0161T. CPT procedure codes 0041T - 0061T are codes effective July 1, 2006.

2. Section 5.1 (Integumentary System). 10021, 10022, 10040 - 11977, 11981 - 11983, 12001 - 15770, 15840 - 15845, 15851 - 19499, 97601, and 97602.

New CPT procedure codes 15040, 15110, 15111, 15115, 15116, 15130, 15131, 15135, 15136, 15150 - 15152, 15155 - 15157, 15170, 15171, 15175, 15176, 15300, 15301, 15320, 15321, 15330, 15331, 15335, 15336, 15340, 15341, 15360, 15361, 15365, and 15366 were added to CPT procedure codes range as payable codes. New CPT procedure codes 15400, 15401, 15420, 15421, 15430 and 15431 were added to exclusions. The new CPT procedure code range is 10021, 10022, 10040 - 11977, 11981 - 11983, 12001 - 15366, 15570 - 15776, 15840 - 15845, 15851 - 19499, 97601, and 97602.

3. Section 6.1 (Musculoskeletal System). 20000 - 22505, 22532 - 22534, 22548 - 29863, 29870 - 29999.

CPT Procedure code range was unchanged. New CPT procedure codes 22010 and 22015 are within procedure code range. Charite artificial disc (spine arthroplasty new Category III codes 0090T - 0098T) was added to exclusions as unproven.

4. Section 9.1 (Cardiovascular System). 33010 - 33130, 33140, 33141, 33200 - 37799, 92950 - 93581, 93745, 93770, 93797 - 93799.

New CPT procedure codes 33507, 33548, 33768, 33880, 33881, 33883, 33884, 33886, 33889, 33891, 33925, 33926, 36598, 37718, and 37722 were added to procedure code range. CPT procedure codes 37184 - 37188 were added to exclusions as unproven. The new CPT procedure code range is 33010 - 33130, 33140, 33141, 33200 - 37183, 37195 - 37785, 92950 - 93581, 93745, 93770, 93797 - 93799.

SUMMARY OF CHANGES (Continued)

CHAPTER 4 (Continued)

5. Section 13.2 (Surgery For Morbid Obesity). 43644, 43842, 43846, and 43848.

No change. New CPT procedure codes were within procedure code range. We added the following to Exclusions: laparoscopy, gastric restrictive procedure (CPT procedure codes 43770 - 43774) and gastric restrictive procedure (CPT procedure codes 43886 - 43888) is unproven. Added "for gastric bypass procedures" for unlisted codes.

6. Section 20.1 (Nervous System). 61000 - 61860, 61863 - 63048, 63055 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979.

Pulmonary arteriovenous malformation (PAVM) was removed from paragraph III.B. because it did not belong in this chapter. New CPT procedure codes 61630, 61635, 61640 - 61642 added to Exclusions. Deleted CPT procedure codes 64561 and 64580 from paragraph IV.J. because they were the wrong codes for this procedure. New CPT procedure code range is 61000 - 61626, 61680 - 61860, 61863 - 63048, 63055 - 64999, 95961, 95962, 95970 - 95975, 95978, 95979.

CHAPTER 5

7. Section 1.1 (Diagnostic Radiology (Diagnostic Imaging)). 70010 - 76083, 76086 - 76394, 76400, 76496 - 76499, 95965 - 95967. New CPT procedure codes 75958, 75959, 73676, and 76377 are within procedure code range.

TRICARE considers three-dimensional (3D) reconstruction (CPT procedure codes 76376 and 76377) medically necessary under certain circumstances. TRICARE does not provide separate reimbursement for 3D reconstruction. TRICARE considers 3D rendering an example of technology and technique improvement in which radiology practices invest as a standard approach to quality improvement.

The following were added to Exclusions:

3D rendering is unproven for the following indications:

Monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

Evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

Use as a screening test for CAD in healthy individuals or in asymptomatic patients who have one or more traditional risk factors for CAD is unproven.

Computed tomography angiography for acute ischemic stroke is unproven.

SUMMARY OF CHANGES (Continued)

CHAPTER 5 (Continued)

Section 1.1 (continued)

Computed tomography angiography for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

Computed tomography, heart, without contrast, including image post processing and quantitative evaluation of coronary calcium (CPT procedure code 0144T) is unproven.

Computed tomography, heart, without contrast material followed by contrast, material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology (CPT procedure code 0145T) is unproven.

Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT procedure code 0146T). Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT procedure code 0147T) is unproven.

Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT procedure code 0148T). Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT procedure code 0149T) is unproven.

Cardiac structure and morphology in congenital heart disease (CPT procedure code 0150T). Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing, function evaluation (left and right ventricular function, ejection fraction and segmental wall (CPT procedure code 0152T)) is unproven.

8. Section 2.1 (Diagnostic Ultrasound).

3D and 4D rendering maternity ultrasound (CPT procedure codes 76376 and 76377) is unproven was added to Exclusions.

SUMMARY OF CHANGES (Continued)

CHAPTER 6

9. Section 1.1 (Pathology and Laboratory - General). 80048 - 807620, 87650 - 87999, 88104 - 89104, 89330 - 89399.

No change to CPT procedure code range. New CPT procedure codes 82271, 82272, 83037, 83631, 83695, 83700, 83701, 83704, 83900, 83907 - 83909, 83914, 86200, 86355, 86357, 86367, 86480, 86923, 87209, 87900, 88333, 88334, 88384 - 88386, 89049 are within procedure code range. Added to Exclusions: CPT procedure codes 83701 and 83704 are not covered for low density lipoprotein (LDL) subclass testing.

Added HPV testing as a covered procedure and deleted HPV testing as an exclusion.

Appendix A

10. New Category II CPT procedure codes include those codes that were effective January 1, 2006 and July 1, 2006. New CPT procedure codes 0001F, 0005F, 0012F, 0505F, 0507F, 1003F - 1008F, 1015F, 1018F, 1019F, 1022F, 1026F, 1030F, 1034F - 1036F, 1038F - 1040F, 2001F - 2004F, 2014F, 2018F, 2022F - 2024F, 2026F, 2028F, 2030F, 2031F, 3000F, 3002F, 3006F, 3011F, 3014F, 3017F, 3020F, 3025F, 3027F, 3028F, 3035F, 3037F, 3040F, 3042F, 3046F - 3050F, 3061F, 3062F, 3066F, 3072F, 3076F - 3080F, 3082F - 3085F, 3088F - 3093F, 4003F, 4012F, 4014F - 4018F, 4025F, 4030F, 4033F, 4035F, 4037F, 4040F, 4045F, 4050F - 4056F, 4059F, 4060F, 4062F, 4064F - 4067F, 6005F were added to procedure code range.

New CPT Procedure code range is: 0001F, 0005F, 0012F, 0500F - 0503F, 0505F, 0507F, 1000F - 1008F, 1015F, 1018F, 1019F, 1022F, 1026F, 1030F, 1034F - 1036F, 1038F - 1040F, 2000F - 2004F, 2010F, 2014F, 2018F, 2022F - 2024F, 2026F, 2028F, 2030F, 2031F, 3000F, 3002F, 3006F, 3011F, 3014F, 3017F, 3020F, 3025F, 3027F, 3028F, 3035F, 3037F, 3040F, 3042F, 3046F - 3050F, 3061F, 3062F, 3066F, 3072F, 3076F - 3080F, 3082F - 3085F, 3088F - 3093F, 4000F - 4003F, 4006F, 4009F, 4011F, 4012F, 4014F - 4018F, 4025F, 4030F, 4033F, 4035F, 4037F, 4040F, 4045F, 4050F - 4056F, 4059F, 4060F, 4062F, 4064F - 4067F, 6005F.

CATEGORY III CODES

ISSUE DATE: March 6, 2002

AUTHORITY: 32 CFR 199.2(b) and 32 CFR 199.4(g)(15)

I. CPT¹ PROCEDURE CODES

0003T, 0008T, 0016T - 0019T, 0021T, 0024T, 0026T - 0032T, 0041T - 0161T

II. DESCRIPTION

Category III codes are a set of temporary codes for emerging technology, services, and procedures. These codes are used to track new and emerging technology to determine applicability to clinical practice. When a category III code receives a Category I code from the AMA it does not automatically become a benefit under TRICARE. However, the codes that may have moved from unproven to proven must be forwarded to the Office of Medical Benefits and Reimbursement Systems (MB&RS) for coverage determination/policy clarification.

III. POLICY

A. Category III codes are to be used instead of unlisted codes to allow the collection of specific data. TRICARE has not opted to track Category III codes at this time.

B. Category III codes are excluded from coverage since clinical safety and efficacy or applicability to clinical practice has not been established.

IV. EXCEPTION

A. Category III code 0024T may be covered under the Rare Disease Policy for children.

B. FDA IDE (Category B) clinical trial. See Chapter 8, Section 5.1.

V. EXCLUSION

Unlisted codes for category II codes. Effective January 1, 2002.

- END -

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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~~, 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. Topical 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.

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.

B. Services performed for cosmetic purposes.

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CHAPTER 4, SECTION 5.1

INTEGUMENTARY SYSTEM

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

D. Endoscopic thoracic sympathectomy when performed for the treatment of hyperhidrosis.

E. Xenograft skin for temporary wound closure, trunk, arms, legs, (CPT² procedure codes 15400 and 15401) is unproven.

F. Xenograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck ears, orbits, genitalia, hands, feet and/or multiple digits (CPT² procedure codes 15420 and 15421) is unproven.

G. Acellular xenograft implant (CPT² procedure codes 15430 and 15431) is unproven.

- END -

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MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

20000 - 22505, 22532 - 22534, 22548 - **28825, 28899** - 29863, **29866, 29867**, 29870 - 29999

II. DESCRIPTION

The musculoskeletal system pertains to or comprises the skeleton and the muscles.

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered. FDA-approved surgically implanted devices are also covered.

B. Effective August 25, 1997, autologous chondrocyte implantation (ACI) surgery for the repair of clinically significant, symptomatic, cartilaginous defects of the femoral condyle (medial, lateral or trochlear) caused by acute or repetitive trauma is a covered procedure. The autologous cultured chondrocytes must be approved by the Food and Drug Administration.

C. Single or multilevel anterior cervical microdiscectomy with allogenic or autogenic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

IV. EXCLUSIONS

A. Percutaneous vertebroplasty (CPT¹ procedure codes 22520-**22525**) is unproven.

B. Percutaneous kyphoplasty (CPT¹ procedure codes 22523-22525) for the treatment of vertebral fractures is unproven.

C. Meniscal transplant (CPT¹ procedure code 29868) for meniscal injury is unproven.

D. Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.

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CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

- E. Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.
- F. Trigger point injection (CPT² procedure codes 20552, 20553) for migraine headaches.
- G. IDET (Intradiscal Electrothermal Therapy) for Chronic Discogenic Pain (CPT² procedure codes 0062T and 0063T) is unproven.
- H. Botox (chemodenervation) for migraine headaches is unproven.
- I. Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT² procedure code 0090T) each additional interspace (CPT² procedure code 0092T) is unproven.
- J. Removal of total disc arthroplasty anterior approach cervical; single interspace (0093T) each additional interspace (CPT² procedure code 0095T). Also see Chapter 4, Section 1.1.
- K. Artificial intervertebral disc replacement for degenerative disc disease (CPT² procedure code 0096T), each additional space (CPT² procedure code 0098T). Also see Chapter 4, Section 1.1.
- L. Extracorporeal shock wave, high energy involving the lantar fascia (CPT² procedure code 28890) because this is for a complication of a noncovered procedure. Also see Chapter 4, Section 1.1.

- END -

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CARDIOVASCULAR SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

33010 - 33130, 33140, 33141, 33200 - 37183, 37195 - 37785, 92950 - 93272, 93303 - 93581, 93600 - 93745, 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 (VADs) (external and implantable) are covered if the device is FDA approved and used in accordance with FDA approved indications. VADs as destination therapy (CPT¹ 33979) are covered if they have received approval from the FDA for that purpose and are used according to the FDA-approved labeling instructions. Benefits are authorized when the procedure is performed at a TRICARE-certified heart transplantation center, a TRICARE-certified pediatric consortium heart transplantation center, or a Medicare facility which is approved for VAD implantation as destination therapy, for patients who meet all of the following conditions:

1. The patient has chronic end-stage heart failure (New York Heart Association Class IV end-stage left ventricular failure for at least 90 days with a life expectancy of less than 2 years).

2. The patient is not a candidate for heart transplantation.

3. The patient's Class IV heart failure symptoms have failed to respond to optimal medical management, including a dietary salt restriction, diuretics, digitalis, beta-blockers, and ACE inhibitors (if tolerated) for at least 60 of the last 90 days.

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CHAPTER 4, SECTION 9.1

CARDIOVASCULAR SYSTEM

4. The patient has left ventricular ejection fraction (LVEF) less than 25%.

5. The patient has demonstrated functional limitation with a peak oxygen consumption of less than 12 ml/kg/min; or the patient has a continued need for intravenous inotropic therapy owing to symptomatic hypotension, decreasing renal function, or worsening pulmonary congestion.

6. The patient has the appropriate body size (by device per FDA labeling) to support the VAD implantation.

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

D. Transmyocardial revascularization (TMR) (CPT² 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.

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.

F. FDA approved IDE clinical trials. See Chapter 8, Section 5.1, paragraph E. and F. for policy.

IV. EXCLUSIONS

A. Thermogram; cephalic (CPT procedure code 93760); peripheral (CPT² procedure code 93762) are unproven.

B. Ambulatory blood pressure monitoring is unproven.

93784 - AMBULATORY BP MONITORING²

93786 - AMBULATORY BP RECORDING²

93788 - AMBULATORY BP ANALYSIS²

93790 - REVIEW/REPORT BP RECORDING²

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

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

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CARDIOVASCULAR SYSTEM

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 (CPT³ procedure code 93278) is unproven.

H. Primary percutaneous transluminal mechanical thrombectomy (CPT³ procedure code 37184) with or without second and all subsequent vessel(s) with the same vascular family (CPT³ procedure code 37185) is unproven.

I. Secondary percutaneous transluminal thrombectomy (CPT³ procedure code 37186) is unproven.

J. Percutaneous transluminal mechanical thrombectomy vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance (CPT³ procedure code 37187) is unproven.

K. Percutaneous transluminal mechanical thrombectomy, vein(s) including intraprocedural pharmacological thrombolytic injections and fluroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy (CPT³ procedure code 37188) is unproven.

V. EFFECTIVE DATES

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

B. January 1, 2002, for TMR.

C. October 1, 2003, for ventricular assist devices as destination therapy.

- END -

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SURGERY FOR MORBID OBESITY

ISSUE DATE: November 9, 1982

AUTHORITY: [32 CFR 199.4\(e\)\(15\)](#)

I. CPT¹ PROCEDURE CODE RANGE

43644, 43842, 43846, and 43848

II. DESCRIPTION

Morbid obesity means the body weight is 100 pounds over ideal weight for height and bone structure, according to the most current Metropolitan Life Table, and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the body weight is 200 percent or more of ideal weight for height and bone structure.

III. POLICY

A. Gastric bypass, gastric stapling or gastroplasty, to include vertical banded gastroplasty is covered when one of the following conditions is met:

1. The patient is 100 pounds over the ideal weight for height and bone structure and has one of these associated medical conditions: diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders and severe arthritis of the weight-bearing joints.

2. The patient is 200 percent or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category.

3. The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown).

B. In determining the ideal body weight for morbid obesity using the Metropolitan Life Table, contractors must apply 100 pounds (or 200%) to both the lower and higher end of the weight range. Payment will be allowed when beneficiaries meet all requirements for morbid obesity surgery including the ideal weight within the newly determined range.

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CHAPTER 4, SECTION 13.2
SURGERY FOR MORBID OBESITY

IV. EXCLUSIONS

- A. Nonsurgical treatment of obesity, morbid obesity, dietary control or weight reduction.
- B. Biliopancreatic bypass (jejunioileal bypass, Scopinaro procedure) for treatment of morbid obesity is unproven (CPT² procedure code 43645, 43845, 43847 or 43633).
- C. Gastric bubble or balloon for treatment of morbid obesity is unproven.
- D. Gastric wrapping/gastric banding (CPT² procedure code 43843) for treatment of morbid obesity is unproven.
- E. Unlisted CPT² procedure codes 43659 (laparoscopy procedure, stomach); 43999 (open procedure, stomach); and 49329 (laparoscopy procedure, abdomen, peritoneum and omentum) for gastric bypass procedures.
- F. Adjustable gastric band (open or laparoscopically) (CPT² procedure codes 43770 - 43774, 43886 - 43888, and 90772 or HCPCS code S2083).

V. EFFECTIVE DATE

Laparoscopic surgical procedure for gastric bypass and gastric stapling (gastroplasty), including vertical banded gastroplasty are covered effective December 2, 2004.

- END -

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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 - 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

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reduce the likelihood of rupture and hemorrhagic stroke. By applying a low voltage direct 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.
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.

1. Implantation of a 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. Coverage may also be provided for beneficiaries under the age of 12 when a physician has attested to the appropriateness in a particular case.

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.

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

IV. EXCLUSIONS

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

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

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

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

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

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

G. Dorsal root entry zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

H. Epidural steroid injections for thoracic pain are unproven.

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

J. Neuromuscular electrical stimulation for the treatment of denervated muscles is unproven.

K. Stereotactic cingulotomy is unproven.

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NERVOUS SYSTEM

L. Sacral nerve neurostimulator (CPT³ procedure codes 64561, 64581, 64585, 64590, and 64595). See [Chapter 4, Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

M. 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).

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

O. 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.

P. 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.

V. EFFECTIVE DATES

A. January 1, 1989, for PAVM.

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

C. July 14, 1997, for GDC.

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

E. June 1, 2004, for Magnetoencephalography.

- END -

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DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

ISSUE DATE: March 7, 1986

AUTHORITY: 32 CFR 199.4(a), (b), (c), and (e)(14) and 32 CFR 199.6(d)(2)

I. CPT¹ PROCEDURE CODES

70010 - 76083, 76086 - 76394, 76400, 76496 - 76499, 95965 - 95967

II. HCPCS PROCEDURE CODES

G0204 - G0207

III. DESCRIPTION

Radiology is the science that deals with the use of radiant energy, such as X-rays, radium, and radioactive isotopes, in the diagnosis and treatment of disease. Radiology is an important diagnostic tool useful for the evaluation. The techniques used for diagnostic radiology are as follows:

Magnetic Resonance Imaging (MRI), formerly also referred to as nuclear magnetic resonance (NMR), is a non-invasive method of graphically representing the distribution of water and other hydrogen-rich molecules in the human body. MRI uses radio frequency radiation in the presence of a carefully controlled magnetic field to produce high quality cross-sectional images of the head and body in any plane. These tomographic images represent the tissue being analyzed and the environment surrounding it. MRI has become a useful diagnostic imaging modality that is capable of demonstrating a wide variety of soft-tissue lesions with contrast resolution equal or superior to computerized tomography (CT) scanning in various parts of the body. Among the advantages of MRI are the absence of ionizing radiation and the ability to achieve high levels of tissue contrast resolution without injected iodinated contrast agents.

Magnetic Resonance Angiography (MRA) techniques generate contrast between flowing blood and surrounding tissue, and provide anatomic images that can be provided in a format similar to that of conventional x-ray angiography, and can also provide physiologic information.

A Computerized Tomography (CT)/Computerized Axial Tomography (CAT) scan is

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DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

interchangeably referred to as either a CT or CAT scan. This diagnostic test uses x-ray technology to create three-dimensional, computerized images of internal organs. However, unlike a traditional x-ray, CT/CAT scans are able to distinguish between obscured and overlapping parts of the body. CAT scans are also capable of producing images of several different internal components, including soft tissue, blood vessels and bones.

IV. POLICY

A. MRI and MRI with contrast media are covered when medically necessary, appropriate, and the standard of care. (CPT² procedure codes 70336, 70540-70543, 70551-70553, 71550-71552, 72141-72158, 72195-72197, 73218-73223, 73718-73723, 74181-74183, 75552-75556, and 76400.)

B. Open MRI and Open MRI with contrast media are covered when medically necessary, appropriate, and the standard of care.

C. MRA is covered when medically necessary, appropriate and the standard of care. (CPT² procedure codes 70544-70549, 71555, 72159, 72198, 73225, 73725, and 74185.)

D. CT scans are covered when medically necessary, appropriate and the standard of care and all criteria stipulated in 32 CFR 199.4(e) are met. (CPT² procedure codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74175, 75635, and 76355-76380.)

E. TRICARE considers three-dimensional (3D) rendering (CPT² procedure codes 76376 and 76377) medically necessary under certain circumstances. Medical necessity must be established prior to procedure. TRICARE does not provide additional reimbursement for 3D rendering. TRICARE considers 3D rendering an example of technology and technique improvement in which radiology practices invest as a standard approach to quality improvement.

F. Helical (spiral) CT scans, with or without contrast enhancement, are covered when medically necessary, appropriate and the standard of care.

G. Chest x-rays (CPT² procedure codes 71010-71035) are covered.

H. Diagnostic mammography (CPT² procedure codes 76090-76092/HCPCS codes G0204-G0207) to further define breast abnormalities or other problems is covered.

I. Portable X-ray services are covered. The suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations, or the Medicaid program in that state in which the covered service is provided. In addition to the specific radiology services, reasonable transportation and set-up charges are covered and separately reimbursable.

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J. Bone density studies (CPT³ procedure codes 76070-76078) are covered for the following:

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 clinical risk for 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.

V. EXCLUSIONS

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

B. Ultrafast CT (electron beam computed tomography (HCPCS code S8092)) to predict asymptomatic heart disease is preventive.

C. MRIs (CPT³ procedure codes 76093 and 76094) to confirm implant rupture in symptomatic patients whose ultrasonography shows rupture, to screen for breast cancer, to evaluate breasts before biopsy, to differentiate benign from malignant breast disease and to differentiate cysts from solid lesions.

D. 3D rendering (CPT³ procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

E. 3D rendering (CPT³ procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

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F. 3D rendering (CPT⁴ procedure codes 76376 and 76377) for use as a screening test for CAD in healthy individuals or in asymptomatic patients who have one or more traditional risk factors for CAD is unproven.

G. Computed tomography angiography (CPT⁴ procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

H. Computed tomography angiography (CPT⁴ procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

I. Computed tomography, heart, without contrast, including image post processing and quantitative evaluation of coronary calcium (CPT⁴ procedure code 0144T) is unproven.

J. Computed tomography, heart, without contrast material followed by contrast, material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology (CPT⁴ procedure code 0145T) is unproven.

K. Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT⁴ procedure code 0146T). Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT⁴ procedure code 0147T) is unproven.

L. Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT⁴ procedure code 0148T). Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT⁴ procedure code 0149T) is unproven.

M. Cardiac structure and morphology in congenital heart disease (CPT⁴ procedure code 0150T). Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing, function evaluation (left and right ventricular function, ejection fraction and segmental wall (CPT⁴ procedure code 0152T)) is unproven.

VI. EFFECTIVE DATE

The effective date for MRIs with contrast media is dependent on the FDA approval of the contrast media and a determination by the contractor of whether the labeled or unlabeled use of the contrast media is medically necessary and a proven indication.

- END -

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DIAGNOSTIC ULTRASOUND

ISSUE DATE: November 1, 1983

AUTHORITY: 32 CFR 199.2, 32 CFR 199.4(a)(1), (b)(2), (b)(3), (b)(4), and (g)(36)

I. CPT¹ PROCEDURE CODE RANGES

Diagnostic Ultrasound: 76506 - 76778, 76801 - 76886

Ultrasonic Guidance: 76930 - 76965

Ultrasound Other: 76970 - 76999

II. DESCRIPTION

The visualization of deep structures of the body by recording the reflections (echoes) of pulses of ultrasonic waves direct into the tissues. Ultrasound is used for diagnostic and guidance purposes.

III. POLICY

A. Ultrasound procedures for diagnosis, guidance, and post-operative evaluation of surgical procedures may be cost-shared.

B. Maternity related ultrasound. Professional and technical components of medically necessary fetal ultrasounds are covered outside the maternity global fee. The medically necessary indications include (but are not limited to) clinical circumstances that require obstetric ultrasounds to: estimate gestational age, evaluate fetal growth, conduct a biophysical evaluation for fetal well being, evaluate a suspected ectopic pregnancy, define the cause of vaginal bleeding, diagnose or evaluate multiple gestations, confirm cardiac activity, evaluate maternal pelvic masses or uterine abnormalities, evaluate suspected hydatidiform mole, and evaluate the fetus' condition in late registrants for prenatal care.

C. Bone Density studies (CPT¹ procedure code 76977) are covered for:

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

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DIAGNOSTIC ULTRASOUND

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 clinical risk for 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. Ultrasound for routine screening for breast disease.

B. Ultrasound performed to determine sex of an unborn child.

C. Bone density studies for routine screening for osteoporosis.

D. Ultrasound, spinal canal and contents (CPT² procedure code 76800) for spinal scanning in adults for inflammatory conditions of the spine and nerve roots or as guidance for facet joint or epidural injections (CPT² procedure codes 76880 and 76942).

E. 3D and 4D maternity ultrasound (CPT² procedure codes 76376 and 76377) is unproven.

- END -

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GENERAL

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(a)(1)(i), (b)(2)(ix), (b)(3)(vi), (c)(2)(x) and (g)(60)

I. CPT¹ PROCEDURE CODES

80048 - 87622, 87650 - 87999, 88104 - 89264, 89330 - 89399

II. DESCRIPTION

A. Pathology is the medical science and specialty practice that deals with all aspects of disease, but with special reference to the essential nature, the causes, and development of abnormal conditions, as well as the structural and functional changes that result from disease processes.

B. The surgical pathology services include accession, examination, and reporting for a specimen which is defined as tissue that is submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. These codes require gross and microscopic examination.

III. POLICY

A. Pathology and laboratory services are covered except as indicated.

B. Surgical pathology procedures, billed by a pathologist, are covered services.

C. If the operating surgeon bills for surgical pathology procedures, they will be denied as incidental, since the definitive (microscopic) examination will be performed later, after fixation of the specimen, by the pathologist who will bill separately.

D. Dermatologists are qualified to perform surgical pathology services. Therefore, if a dermatologist bills for both the surgical procedure (e.g. CPT¹ procedure code 11100, skin biopsy) as well as the surgical pathology, both procedures are covered in full.

E. Human papillomavirus testing (CPT¹ procedure codes 87620 - 87622) is covered for the assessment of women with atypical squamous cells of undetermined significance (ASCUS) or low-grade squamous intraepithelial (LSIL) cells detected upon initial pap smear.

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- F. For Transfusion Services refer to [Chapter 6, Section 2.1](#).

IV. EXCLUSIONS

- A. Autopsy and postmortem (CPT² procedure codes 88000-88099).
- B. Sperm penetration assay (hamster oocyte penetration test or the zona-free hamster egg test) is **excluded for IVF** (CPT² procedure code 89329).
- C. In-vitro chemoresistance and chemosensitivity assays (stem cell assay, differential staining cytotoxicity assay and thymidine incorporation assay) are unproven.
- D. Hair analysis to identify mineral deficiencies from the chemical composition of hair is unproven. Hair analysis testing (CPT² procedure code 96902) may be reimbursed when necessary to determine lead poisoning.
- E. Insemination of oocytes (CPT² procedure code 89268).
- F. Extended culture of oocyte(s) embryo(s) 4-7 days (CPT² procedure code 89272).
- G. Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes (CPT² procedure code 89280).
- H. Assisted oocyte fertilization, microtechnique; greater than 10 oocytes (CPT² procedure code 89281).
- I. Biopsy oocyte polar body or embryo blastomere (CPT² procedure code 89290).
- J. Biopsy oocyte polar body or embryo blastomere; greater than 4 embryos (CPT² procedure code 89291).
- K. Cryopreservation reproductive tissue, testicular (CPT² procedure code 89335).
- L. Storage (per year) embryo(s) (CPT² procedure code 89342).
- M. Storage (per year) sperm/semen (CPT² procedure code 89343).
- N. Storage (per year) reproductive tissue, testicular/ovarian (CPT² procedure code 89344).
- O. Storage (per year) oocyte (CPT² procedure code 89346).
- P. Thawing of cryopreserved, embryo(s) (CPT² procedure code 89352).
- Q. Thawing of cryopreserved, sperm/semen, each aliquot (CPT² procedure code 89353).

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GENERAL

R. Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT³ procedure code 89354).

S. Thawing of cryopreserved, oocytes, each aliquot (CPT³ procedure code 89356).

T. CPT³ procedure codes 83701, and 83704 and not covered for low density lipoprotein (LDL) subclass testing.

- END -

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APPENDIX A

CATEGORY II CODES - PERFORMANCE MEASUREMENT

ISSUE DATE: October 15, 2003

AUTHORITY: 32 CFR 199.17(j) and (p)(3)

I. CPT¹ PROCEDURE CODES

0001F, 0005F, 0012F, 0500F - 0503F, 0505F, 0507F, 1000F - 1008F, 1015F, 1018F, 1019F, 1022F, 1026F, 1030F, 1034F - 1036F, 1038F - 1040F, 2000F - 2004F, 2010F, 2014F, 2018F, 2022F - 2024F, 2026F, 2028F, 2030F, 2031F, 3000F, 3002F, 3006F, 3011F, 3014F, 3017F, 3020F, 3025F, 3027F, 3028F, 3035F, 3037F, 3040F, 3042F, 3046F - 3050F, 3061F, 3062F, 3066F, 3072F, 3076F - 3080F, 3082F - 3085F, 3088F - 3093F, 4000F - 4003F, 4006F, 4009F, 4011F, 4012F, 4014F - 4018F, 4025F, 4030F, 4033F, 4035F, 4037F, 4040F, 4045F, 4050F - 4056F, 4059F, 4060F, 4062F, 4064F - 4067F, 6005F

II. DESCRIPTION

The CPT Category II codes are supplemental tracking codes that can be used for performance measurement.

III. POLICY

Category II codes are to be used to collect data about the quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care.

IV. EFFECTIVE DATE January 1, 2004.

- END -

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