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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 73
6010.54-M
APRIL 1, 2008

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: PERCUTANEOUS VERTEBROPLASTY AND
KYPHOPLASTY (EVOLVING PRACTICE)

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change adds percutaneous vertebroplasty and
balloon kyphoplasty for the treatment of painful osteolytic lesions and osteoporotic
compression fractures refractory to conservative medical treatment. This change also
adds radiologic supervision and interpretation, percutaneous vertebroplasty or
vertebral augmentation including cavity creation, per vertebral body; under
fluoroscopic guidance or under Computerized Tomography (CT) guidance.

EFFECTIVE DATE: March 1, 2007.

IMPLEMENTATION DATE: May 1, 2008.


Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

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

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

CHANGE 73
6010.54-M
APRIL 1, 2008

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 17.1, pages 1 and 2

Section 17.1, pages 1 and 2

CHAPTER 4

Section 6.1, pages 1 and 2

Section 6.1, pages 1 and 2

CHAPTER 5

Section 1.1, pages 3 through 5

Section 1.1, pages 3 through 5

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND "S" CODES

ISSUE DATE: November 6, 2007

AUTHORITY:

I. HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

II. DESCRIPTION

A. HCPCS "C" codes include device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals that do not have other HCPCS assigned.

B. HCPCS "S" codes are temporary codes used by the private sector to report drugs, services, and supplies for which there are no national codes.

III. POLICY

A. Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For hospital outpatient department (HOPD) services provided prior to the implementation of TRICARE's OPPS, and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 34, paragraph III.B](#).

B. Under TRICARE, "S" codes are not reimbursable except as follows:

1. S9122, S9123, and S9124 for the ECHO respite care benefit and the ECHO Home Health Care (EHHC) benefit; and

2. S0812, S1030, S1031, S1040, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, **S2360, S2361**, S2400, S2401, S2402, S2403, S2405, S2411, S3818, S3819, S3820, S3822, S3823, S8185, S8265, S8270, and S9430 for all beneficiaries; and

3. S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries and S5110 for training services provided to family members of beneficiaries receiving EIA services under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 20, Section 10](#)).

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002
CHAPTER 1, SECTION 17.1
HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND
"S" CODES

C. Under TRICARE, HCPCS code S9999 is a recognized code for purposes of reporting sales tax but is not payable.

IV. EXCLUSIONS

HCPCS "C" codes are not allowed to be billed by independent professional providers.

- END -

MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

20000 - 22505, 22520 - 22525, 22532 - 22534, 22548 - 28825, 28899 - 29863, 29866, 29867, 29870 - 29999

II. HCPCS CODES

S2360, S2361

III. DESCRIPTION

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

IV. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered. U.S. Food and Drug Administration (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 FDA.

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.

D. Percutaneous vertebroplasty (CPT¹ procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes 22523-22525) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

V. EXCLUSIONS

- A. Meniscal transplant (CPT² procedure code 29868) for meniscal injury is unproven.
- B. Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.
- C. Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.
- D. Trigger point injection (CPT² procedure codes 20552, 20553) for migraine headaches.
- E. IDET (Intradiscal Electrothermal Therapy) for Chronic Discogenic Pain (CPT² procedure codes 0062T and 0063T) is unproven.
- F. Botox (chemodenervation) for migraine headaches is unproven.
- G. 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.
- H. 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](#).
- I. Artificial intervertebral disc replacement for degenerative disc disease is unproven (CPT² procedure codes 0090T - 0098T).
- J. Extracorporeal shock wave, high energy involving the plantar fascia (CPT² procedure code 28890).
- K. X STOP Interspinous Process Decompression System for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.
- L. Hip core decompression is unproven.

VI. EFFECTIVE DATE

March 1, 2007, for percutaneous vertebroplasty and balloon kyphoplasty.

- END -

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

F. TRICARE considers three-dimensional (3D) rendering (CPT³ procedure codes 76376 and 76377) medically necessary under certain circumstances (see [Chapter 5, Section 2.1](#)).

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

H. Chest x-rays (CPT³ procedure codes 71010-71035) are covered.

I. Diagnostic mammography (CPT³ procedure codes 76090-76092/HCPCS codes G0204-G0207) to further define breast abnormalities or other problems is covered.

J. 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.

K. 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.

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L. Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT⁴ procedure code 72291) or under CT guidance (CPT⁴ procedure code 72292) is covered.

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 (CPT⁴ procedure codes 76058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.

D. MRIs (CPT⁴ procedure codes 76058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.

E. 3D rendering (CPT⁴ procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

F. 3D rendering (CPT⁴ procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

G. 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.

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

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

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

K. 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.

L. 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

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluative of coronary calcium (CPT⁵ procedure code 0147T) is unproven.

M. 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 (CPT⁵ 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 (CPT⁵ procedure code 0149T) is unproven.

N. Cardiac structure and morphology in congenital heart disease (CPT⁵ 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 motion (CPT⁵ procedure code 0152T)) is unproven.

VI. EFFECTIVE DATES

A. The effective date for MRIs with contrast media is dependent on the **U.S. Food and Drug Administration (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.

B. March 31, 2006, for breast MRI.

C. **March 1, 2007, for CPT⁵ procedure codes 72291 and 72292.**

- END -

