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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 83
6010.54-M
AUGUST 14, 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: 2007 CPT UPDATES

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): There were 645 coding changes made in the 2007
Current Procedure Terminology (CPT). New codes were added to the appropriate
policy and deleted codes were replaced with new codes. All changes are either
administrative or updates to the manual.

EFFECTIVE DATE: January 1, 2007.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Branch

ATTACHMENT(S): 9 PAGE(S)
DISTRIBUTION: 6010.54-M

CHANGE 83
6010.54-M
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REMOVE PAGE(S)

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SUMMARY OF CHANGES

CHAPTER 3

1. Section 1.1. Added new CPT¹ procedure codes 00625 and 00626 to CPT procedure codes. New CPT¹ procedure codes are 00625, 00626, 00100 - 01999, 99100, 99116, 99135, 99140.

CHAPTER 4

2. Section 5.7. Deleted CPT¹ procedure codes 19140 and 19182. New CPT¹ procedure codes 19300 (mastectomy for gynecomastia), 19304 (subcutaneous mastectomy) were added. New CPT¹ procedure codes are 19300, 19304, and 19318.
3. Section 9.1. No change to policy. New CPT¹ procedure codes 33202, 33203, 33254 - 33256, 33265, 33266, 33675 - 33677, 33724, 33726, 35302 - 35306, 35537 - 35540, 35637, 35638, 35883, 35884, and 37210 are currently covered and are within CPT procedure codes.
4. Section 15.1. No change to policy. New CPT¹ procedure codes 54865, 55875, and 55876 are currently covered and are within CPT procedure codes.
5. Section 17.1. No change to policy. New CPT¹ procedure codes 56442, 57296, 57558, 58541 - 58546, 58548, 58957, and 58958 are currently covered and are within CPT procedure codes.
6. Section 20.1. No change to policy. New CPT¹ procedure codes 64910 and 64911 are currently covered and are within CPT procedure codes.
7. Section 21.1. No change to policy. New CPT¹ procedure code 67346 is currently covered and is within CPT procedure codes.

CHAPTER 5

8. Section 2.1. No change to policy. New CPT¹ procedure codes 76776, 76813, 76814 and 76998 are currently covered and are within CPT procedure codes.
9. Section 2.2. No change to policy. New HCPCS procedure codes G0008 - G0010.
10. Section 3.1. No change to policy. New CPT¹ procedure codes 77371 - 77373, and 77435 are currently covered and are within CPT procedure codes.

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SUMMARY OF CHANGES (Continued)

CHAPTER 6

11. Section 3.1. Added CPT procedure codes to policy. New CPT² procedure code is 96040.

CHAPTER 7

12. Section 2.1. No change to policy. New HCPCS procedure codes G0008 - G0010.

13. Section 5.1. No change to policy. New CPT² procedure code 91111 is currently covered and is within CPT procedure codes.

14. Section 6.1. No change to policy. New CPT² procedure code 92025 is currently covered and is within CPT procedure codes.

15. Section 8.1. Add new CPT² procedure code 92640. New CPT² procedure codes are 92502 - 92512, 92516, 92520, 92526, 92551 - 92597, 92601 - 92617, 92626, 92627, 92630, 92633, 92640, 92700.

16. Section 13.1. Add new CPT² procedure codes 94002 - 94005. New CPT² procedure codes 94610, 94644, 94645, 94774 - 94777 are currently covered and within CPT procedure codes. New CPT² procedure codes are 94002 - 94005, 94010 - 94799.

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ANESTHESIA

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(b)(2)(viii), (c)(2)(vii), (c)(3)(viii), and (g)(15)

I. CPT¹ PROCEDURE CODES

00100 - 01999, 00625, 00626, 99100, 99116, 99135, 99140

II. POLICY

A. Anesthesia services and supplies are covered.

B. See [Chapter 3, Section 1.2](#) for conscious sedation.

See the TRICARE Reimbursement Manual ([TRM](#)), [Chapter 1, Section 9](#) for information on reimbursement of anesthesia.

III. EXCLUSIONS

A. Hypnotherapy.

B. A separate benefit is not payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical or dental assistant. This exclusion does not apply to cases involving administration of local or regional anesthesia such as local anesthesia administered by a surgeon in the surgeon's office, by an obstetrician in a delivery room, or by an orthopedic surgeon in an operating room.

- END -

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GYNECOMASTIA

ISSUE DATE: May 18, 1994

AUTHORITY: [32 CFR 199.4](#)

I. CPT¹ PROCEDURE CODES

19300, 19304, 19318

II. DESCRIPTION

A. Pathological gynecomastia (ICD-9-CM 611.1) is an abnormal enlargement of the male mammary glands. Some causes of pathological gynecomastia are testicular or pituitary tumors, some syndromes of male hypogonadism, cirrhosis of the liver, administration of estrogens for prostatic carcinoma, and therapy with steroidal compounds.

B. Physiological (pubertal) gynecomastia occurs in teenage boys, usually between the ages of 13-15. In more than 90% of these boys, the condition resolves within a year. Gynecomastia persisting beyond one (1) year is severe and is usually associated with pain in the breast from distension (ICD-9-CM 611.71) and fibrous tissue stroma.

III. POLICY

Benefits may be cost-shared for medically necessary medical, diagnostic, and surgical treatment.

NOTE: Coverage criteria for surgical interventions may include, but is not limited to: severe gynecomastia (enlargement has not resolved after one year); fibrous tissue stroma exists; or breast pain.

IV. EXCLUSION

Surgical treatment performed purely for psychological reasons.

- END -

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DIAGNOSTIC GENETIC TESTING AND COUNSELING

ISSUE DATE: March 10, 2000

AUTHORITY: [32 CFR 199.4\(a\)\(1\)\(i\)](#)

I. CPT¹ PROCEDURE CODE

96040

II. DESCRIPTION

Genetic testing intended to be confirmatory of a clinical diagnosis which is already suspected based on the patient's symptoms.

III. POLICY

A. Genetic counseling provided by an otherwise authorized provider is covered and must precede the actual diagnostic genetic testing.

B. Diagnostic genetic testing when medically proven and appropriate and when the results of the test will influence the medical management of the individual is a TRICARE benefit.

C. The following diagnostic tests are covered. This is not an all inclusive list, but provides examples of covered diagnostic tests.

1. Chromosome analysis (to include karyotyping and/or high resolution chromosome analysis) in some cases of habitual abortion or infertility.

2. Testing for Marfan Syndrome and chromosome analysis (to include karyotyping and/or high resolution chromosome analysis) of children. Common indications for chromosome analysis in children to include ambiguity of external genitalia, small-for-gestational age infants, multiple anomalies and failure to thrive.

3. Other medically necessary genetic diagnostic tests.

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CHAPTER 6, SECTION 3.1

DIAGNOSTIC GENETIC TESTING AND COUNSELING

IV. EXCLUSION

Routine genetic testing that does not influence the beneficiary's medical management.

- END -

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(e\)\(3\)\(ii\)](#) and [\(g\)\(37\)](#)

I. CPT¹ PROCEDURE CODES

45300 - 45339, 45355 - 45385, 77058, 77059, 80061, 82270, 82274, 84153, 86580, 86585, 86762, 87340, 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, 88175, 90281 - 90396, 99172, 99173, 99201 - 99215, 99381 - 99387, 99391 - 99397

II. HCPCS AND TEMPORARY PROCEDURE CODES

A. Level II Codes **G0008 - G0010**, G0104, G0105, G0121, G0202

B. Level III Codes 0066T, 0067T - Specific criteria must be met for coverage of these codes. See [paragraph IV.A.1.c\(5\)](#) for coverage criteria.

III. BACKGROUND

A. The National Defense Authorization Act for Fiscal Year (NDAA FY) 1996 (P.L. 104-106, Section 701) signed into effect on February 10, 1996, expands well-baby visits and immunizations to family members under the age of six and establishes immunizations and comprehensive preventive benefits for family members age six and above to include health promotion and disease preventive visits provided in connection with immunizations, Papanicolaou (Pap) smears, and mammograms. The NDAA FY 1997 (P.L. 104-201, Section 701) signed into effect on September 23, 1996, further expands health care preventive services for colon and prostate cancer examinations. Periodic health examinations that include risk assessment, physical examination, laboratory tests, x-rays, and risk specific counseling will allow for the prevention, early detection and treatment of diseases before they manifest themselves as major health problems. Prior to these Acts, preventive services were quite limited. In addition to Pap smears, mammograms, and well-baby care up to the age of two, the only related services authorized under Extra and Standard plans in the absence of symptoms were immunizations for family members accompanying an active duty member on overseas duty. The expanded preventive services will generally be reflective of those currently being offered to Prime enrollees under the Uniform Health Maintenance Organization (HMO) Benefit (see [32 CFR 199.18\(b\)\(2\)](#)), except for the application of appropriate cost-sharing and deductibles under Extra and Standard plans.

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B. While immunizations are provided as a specific exception to the general preventive care exclusion under the Regulation (32 CFR 199.4(g)(37)) and can be provided independently of other preventive services for those age six and older, the other expanded services (i.e., preventive services reflective of those currently being offered to Prime enrollees under Uniform HMO Benefit) must be provided in connection with immunizations, Pap smears, mammograms, and other cancer screening authorized by 10 U.S.C. 1079. For example, if a eligible female goes in for a routine Pap smear, she is also eligible to receive a wide variety of other preventive services such as tuberculosis screening, rubella antibody screening, blood pressure screening, cholesterol screening test and preventive counseling services, to name a few. However, the same coverage will not be extended if she simply makes an appointment for a routine health promotion visit, where one or more of the associated preventive services (i.e., Pap smear, mammogram, immunization and/or other cancer screening authorized by 10 U.S.C. 1079) are not performed.

C. Preventive physical examinations (for example, oral cavity examinations for pharyngeal cancer, palpation for thyroid nodules, skin cancer screening, and examinations for testicular cancer) are paid under the same comprehensive health promotion and disease prevention examination office visit code (CPT² procedure codes 99381-99387 and 99391-99397) as the associated Pap smear, mammogram, immunization or other cancer screening examination authorized by 10 U.S.C. 1079. In other words, these additional physical examinations are being performed during the same office visit as required to perform the associated Pap smear, mammogram, immunization or other cancer screening authorized by 10 U.S.C. 1079.

IV. POLICY

Preventive care is not directly related to specific illness, injury, a definitive set of symptoms, or obstetrical care, but rather is performed as a periodic health screening, health assessment, or periodic health maintenance. The following services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health:

A. Health Promotion and Disease Prevention Examinations. The following prevention services are specific exceptions to the general preventive care exclusion under the Regulation. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the following preventive services are individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below:

1. Cancer Screening Examinations and Services.

a. Breast Cancer.

(1) Physical Examination. For women under age 40, physicians may elect to perform clinical breast examination for those who are at high risk, especially those whose first-degree relatives have had breast cancer diagnosed before menopause. For women age 40 and older, annual clinical examinations should be performed.

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SPECIAL OTORHINOLARYNGOLOGIC SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: 32 CFR 199.4(c)(3)(iv), (g)(45), (g)(47), and 32 CFR 199.5(c)

I. CPT¹ PROCEDURE CODES

92502 - 92512, 92516, 92520, 92526, 92551 - 92597, 92601 - 92617, 92626, 92627, 92630, 92633, 92640, 92700

II. DESCRIPTION

Otolaryngology is that branch of medicine concerned with the screening, diagnosis and management of medical and surgical disorders of the ear, the upper respiratory and upper alimentary systems and related structures and the head and neck.

Audiology is the discipline involved in the prevention, identification and the evaluation of hearing disorders, the selection and evaluation of hearing aids, and the re-habilitation of individuals with hearing impairment. Audiological services, including function tests, performed to provide medical diagnosis and treatment of the auditory system.

III. POLICY

A. Otorhinolaryngology services, including audiological services are covered for the diagnosis and treatment of a covered medical condition.

B. For services prior to September 1, 2005, hearing aid services and supplies may be cost-shared only for active duty beneficiaries through the basic program.

C. For services on or after September 1, 2005, hearing aid services and supplies may be cost-shared only for Active Duty Family Members (ADFMs) with a profound hearing loss through the TRICARE Basic Program. See [Chapter 7, Section 8.2](#).

D. Diagnostic analysis of cochlear implant with programming is covered for patients under seven years of age (CPT¹ procedure codes 92601, 92602), and age seven years or older with programming (CPT¹ procedure codes 92603, 92604). See [Chapter 4, Section 22.2](#).

E. Evaluation for prescription of non-speech-generating augmentative and alternative communication device, including programming and modification, may be cost-shared only

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CHAPTER 7, SECTION 8.1

SPECIAL OTORHINOLARYNGOLOGIC SERVICES

for eligible beneficiaries through the Extended Care Health Option (ECHO) on the basis of a speech disability or of multiple disabilities, one of which involves a speech disability (CPT² procedure codes 92605 - 92609).

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PULMONARY SERVICES

ISSUE DATE: April 19, 1983

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

I. CPT¹ PROCEDURE CODES

94002 - 94005, 94010 - 94799

II. DESCRIPTION

Services provided for the diagnosis or treatment of conditions involving the lungs.

III. POLICY

A. Pulmonary services including pulmonary services provided as part of a treatment program on an inpatient or outpatient basis are covered.

B. For an indication to be covered the efficacy of the pulmonary services must be proven.

NOTE: Examples of proven indications are: cardiopulmonary or pulmonary rehabilitation for pre- and post-lung transplant patients when preauthorized by the appropriate preauthorizing authority as outlined in the Policy on heart-lung and lung transplantation; effective September 13, 1999, severe Chronic Obstructive Pulmonary Disease (COPD) on an inpatient basis; and moderate and severe COPD on an outpatient basis.

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