



DEFENSE  
HEALTH AGENCY

**MB&RS**

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS  
16401 EAST CENTRETECH PARKWAY  
AURORA, CO 80011-9066

**CHANGE 140  
6010.57-M  
AUGUST 24, 2015**

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**SUMMARY OF CHANGE(S):** See page 3.

**EFFECTIVE DATE:** See page 3

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**This change is made in conjunction with Feb 2008 TRM, Change No. 115 and Feb 2008 TSM, Change No. 76.**

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**Ann N. Fazzini  
Team Chief, Medical Benefits &  
Reimbursement Section (MB&RS)  
Defense Health Agency (DHA)**

**ATTACHMENT(S): 2 PAGE(S)  
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**REMOVE PAGE(S)**

**CHAPTER 4**

Section 6.1, pages 1 and 2

**INSERT PAGE(S)**

Section 6.1, pages 1 and 2

**SUMMARY OF CHANGES**

**CHAPTER 4**

1. Section 6.1. This change reflects new Coding Exclusions related to Cervical Total Disc Replacement.  
EFFECTIVE DATE: 01/01/2015.



## Musculoskeletal System

Issue Date: August 26, 1985

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

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

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

### 2.0 HCPCS CODES

**S2325**, S2360, S2361

### 3.0 DESCRIPTION

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

### 4.0 POLICY

**4.1** 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.

**4.2** 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.

**4.3** Single or multilevel anterior cervical microdiscectomy with allogeneic or autogeneic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

**4.4** Percutaneous vertebroplasty (CPT<sup>1</sup> procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT<sup>1</sup> procedure codes 22523-22525) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

**4.5** Total Ankle Replacement (TAR) (CPT<sup>1</sup> procedure codes 27702 and 27703) surgery is covered if the device is FDA approved and the use is for an FDA approved indication. However, a medical necessity review is required in case of marked varus or valgus deformity.

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**4.6** Core decompression of the femoral head (hip) for early (precollapse stage I or II) avascular necrosis may be considered for cost-sharing.

**4.7** Single-level, cervical Total Disc Replacement (TDR) (CPT<sup>2</sup> procedure code 22856) using an FDA approved cervical artificial intervertebral disc for the treatment of cervical DDD, intractable radiculopathy, and/or myelopathy is covered if the disc is used in accordance with its FDA labeled indications.

**4.8** High Energy Extracorporeal Shock Wave Therapy (HE ESWT) for the treatment of plantar fasciitis is covered when all of the following conditions are met:

- Patients have chronic plantar fasciitis of at least six months duration;
- Patients have undergone and failed six months of appropriate conservative therapy; and
- HE ESWT is defined as Energy Flux Density (EFD) greater than 0.12 millijoules per square millimeter (mJ/mm<sup>2</sup>).

## **5.0 EXCLUSIONS**

**5.1** Meniscal transplant (CPT<sup>2</sup> procedure code 29868) for meniscal injury is unproven.

**5.2** Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.

**5.3** Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.

**5.4** Trigger point injection (CPT<sup>2</sup> procedure codes 20552 and 20553) for migraine headaches.

**5.5** Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), cervical, **second level** (CPT<sup>2</sup> procedure code 22858) and **three or more levels** (CPT<sup>2</sup> procedure code 0375T) is unproven.

**5.6** Removal of total disc arthroplasty (artificial disc), anterior approach, cervical, each additional interspace (CPT<sup>2</sup> procedure code 0095T) is unproven. Also, see [Section 1.1](#).

**5.7** Lumbar total disc arthroplasty (lumbar artificial intervertebral disc revision including replacement, lumbar total disc replacement) for degenerative disc disease is unproven (CPT<sup>2</sup> procedure codes 22857, 22862, 0163T, 0164T, and 0165T).

**5.8** Low Energy (LE) or radial ESWT for the treatment of plantar fasciitis is unproven. Any form of ESWT for the treatment of lateral epicondylitis is unproven.

**5.9** XSTOP Interspinous Process Decompression System (CPT<sup>2</sup> procedure codes 0171T and 0172T, HCPCS code C1821) for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

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