



DEFENSE  
HEALTH AGENCY

**MB&RS**

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

**CHANGE 156  
6010.57-M  
FEBRUARY 10, 2016**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

The Defense Health Agency has authorized the following addition(s)/revision(s).

**CHANGE TITLE: REIMBURSEMENT AND CODING UPDATES 15-004**

**CONREQ: 17757**

**PAGE CHANGE(S): See page 2.**

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

**EFFECTIVE DATE: See page 3.**

**IMPLEMENTATION DATE: March 10, 2016.**

**This change is made in conjunction with Feb 2008 TRM, Change No. 126.**

GREEN.ELAN.P  
ARKER.1386505  
752

Digitally signed by  
GREEN.ELAN.PARKER.1386505752  
DN: c=US, o=U.S. Government, ou=DoD,  
ou=PKI, ou=DHA,  
cn=GREEN.ELAN.PARKER.1386505752  
Date: 2016.02.09 08:40:39 -07'00'

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

**ATTACHMENT(S): 9 PAGE(S)  
DISTRIBUTION: 6010.57-M**

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

**CHANGE 156**  
**6010.57-M**  
**FEBRUARY 10, 2016**

**REMOVE PAGE(S)**

**CHAPTER 1**

Section 3.1, page 3

**CHAPTER 4**

Section 6.1, pages 1 - 4

Section 9.1, pages 1 and 2

Section 18.3, pages 1 and 2

**INSERT PAGE(S)**

Section 3.1, page 3

Section 6.1, pages 1 - 4

Section 9.1, pages 1 and 2

Section 18.3, pages 1 and 2

## **SUMMARY OF CHANGES**

### **CHAPTER 1**

1. Section 3.1. This change updates the CPT code for intravenous immune globulin for the treatment of Hashimoto's Encephalopathy. EFFECTIVE DATE: 01/09/2015.

### **CHAPTER 4**

2. Section 6.1. This change updates the CPT codes for treatment of Femoroacetabular Impingement (FAI) Syndrome - Exclusions and others. EFFECTIVE DATE: As Stated in the Issuance.
3. Section 9.1. This change removes CPT T codes 0256T, 0257T, 0258T, 0259T, 0318T and replaces them with Category 1 CPT codes 33361- 33369 for Transcatheter Aortic Valve Replacement (TAVR) for the treatment of severe symptomatic aortic stenosis. EFFECTIVE DATE: 07/27/2012.
4. Section 18.3. This change adds HCPCS code S0199 per the implementation of Section 704 of the National Defense Authorization Act (NDAA) of 2013. EFFECTIVE DATE: 01/02/2013.



**2.13** Effective February 4, 2011, Radiesse® Voice laryngoplasty injections may be cost-shared for the treatment of type 1 laryngeal cleft (also described as supraglottic interarytenoid defects that extend no further than the true vocal folds).

**2.14** Effective November 27, 1995, Orthotopic Liver Transplantation (OLT) may be cost-shared for the treatment of Crigler-Najjar Syndrome Type I. OLT may be performed both prior to the onset of neurological symptoms or after the onset of neurological symptoms.

**2.15** Effective June 5, 2013, off-label use of intravenous immune globulin for the treatment of Hashimoto's Encephalopathy, may be considered in exceptional circumstances where there is progressive neurological decline despite appropriate steroid therapy or where steroid therapy is contraindicated.

**2.16** Effective January 4, 2013, allogeneic hematopoietic cell transplant (CPT<sup>2</sup> procedure code 38240) for the treatment of primary plasma cell leukemia.

**2.17** Off-label use of Photodynamic Therapy (CPT<sup>2</sup> procedure code 67221) with Visudyne (HCPCS J3396) may be considered for cost-sharing for the treatment of retinal astrocytic hamartoma in Tuberous Sclerosis. The effective date is February 1, 2008.

**2.18** Effective June 25, 2014, intracranial angioplasty with stenting (CPT<sup>2</sup> procedure code 61635) of the venous sinuses may be considered for cost-sharing for the treatment of pseudotumor cerebri (also known as idiopathic intracranial hypertension and benign intracranial hypertension).

**2.19** Effective February 1, 2012, OLT (CPT<sup>2</sup> procedure code 47135) for the treatment of Acute Intermittent Porphyria.

### **3.0 EXCLUSIONS**

**3.1** The off-label use of rituximab for the treatment of pediatric linear Immunoglobulin A (IgA) dermatosis is unproven.

**3.2** Proton Beam Therapy (PBT)/radiosurgery/radiotherapy for the treatment of thymoma is unproven.

- END -



## Chapter 4

## Section 6.1

# Musculoskeletal System

Issue Date: August 26, 1985

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

---

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

20005 - 20551, 20555 - 22328, 22510 - 22515, 22532 - 22856, 22861, 22864 - 27138, 27146 - 27178, 27181 - 29861, 29870 - 29913, 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 [22510-22512](#), S2360, S2361) and balloon kyphoplasty (CPT<sup>1</sup> procedure codes [22513-22515](#)) 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.

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**4.6** Core decompression of the femoral head (hip) for early (precollapse stage I or II) avascular necrosis may be considered for cost-sharing ([Healthcare Common Procedure Coding System \(HCPCS\) code S2325](#)).

**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.

---

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**5.9** XSTOP Interspinous Process Decompression System (CPT<sup>3</sup> procedure codes 0171T and 0172T, HCPCS code C1821) for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

**5.10** Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT<sup>3</sup> procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

**5.11** Hip arthroscopy with debridement of articular cartilage (CPT<sup>3</sup> procedure code 29862) for the treatment of FAI is unproven.

**5.12** Hip arthroscopy with femoroplasty (CPT<sup>3</sup> procedure code 29914) treatment of FAI; cam lesion is unproven.

**5.13** Hip arthroscopy with acetabuloplasty (CPT<sup>3</sup> procedure code 29915) treatment of FAI; pincer lesion is unproven.

**5.14** Hip arthroscopy with labral repair (CPT<sup>3</sup> procedure code 29916) for treatment of FAI syndrome is unproven.

**5.15** Osteochondral allograft of the humeral head with meniscal transplant and glenoid microfracture in the treatment of shoulder pain and instability is unproven.

**5.16** Thermal Intradiscal Procedures (TIPs) (CPT<sup>3</sup> procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (IDTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as Percutaneous Radiofrequency (RF) Thermomodulation or Percutaneous Plasma Discectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

**5.17** Total hip resurfacing (HCPCS code S2118) for treatment of degenerative hip disease is unproven.

**5.18** Spinal manipulation under anesthesia (CPT<sup>3</sup> procedure codes 00640 and 22505) for the treatment of back pain is unproven.

**5.19** Minimally Invasive Lumbar Decompression (mild<sup>®</sup>) for the treatment of Degenerative Disc Disease (DDD) and/or spinal stenosis is unproven.

**5.20** ACI surgery for the repair of patellar cartilage lesions is unproven.

**5.21** iFuse Implant System (CPT<sup>3</sup> procedure code 27279) for treatment of sacroiliac joint pain is unproven.

---

<sup>3</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**TRICARE Policy Manual 6010.57-M, February 1, 2008**

Chapter 4, Section 6.1

Musculoskeletal System

---

**5.22** Athletic pubalgia surgery is unproven.

**6.0 EFFECTIVE DATES**

**6.1** February 6, 2006, for percutaneous vertebroplasty and balloon kyphoplasty.

**6.2** May 1, 2008, for TAR.

**6.3** May 1, 2008, for core decompression of the femoral head.

**6.4** December 24, 2012, for single-level, cervical TDR using an FDA approved cervical artificial intervertebral disc.

**6.5** December 2, 2013, for HE ESWT for plantar fasciitis.

- END -

## Cardiovascular System

Issue Date: August 26, 1985

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

---

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

33010 - 33130, 33140, 33141, 33361 - 33369, 33200 - 37186, 37195 - 37785, 92950 - 93272, 93303 - 93581, 93600 - 93745, 93770, 93797 - 93799, 0075T, 0076T

### 2.0 DESCRIPTION

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

### 3.0 POLICY

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

**3.2** Ventricular Assist Devices (VADs).

**3.2.1** VADs (external and implantable) are covered if the device is U.S. Food and Drug Administration (FDA) approved and used in accordance with FDA approved indications.

**3.2.2** VADs as destination therapy (CPT<sup>1</sup> procedure code 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:

**3.2.2.1** 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 two years).

**3.2.2.2** The patient is not a candidate for heart transplantation.

**3.2.2.3** 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.

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

**3.2.2.4** The patient has Left Ventricular Ejection Fraction (LVEF) less than 25%.

**3.2.2.5** 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.

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

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

**3.4** Transmyocardial Revascularization (TMR) (CPT<sup>2</sup> procedures codes 33140 and 33141).

**3.4.1** 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.

**3.4.2** 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.

**3.5** TMR as an adjunct to Coronary Artery Bypass Graft (CABG) is covered for patients with documented areas of the myocardium that are not amenable to surgical revascularization due to unsuitable anatomy.

**3.6** FDA approved IDE clinical trials. See [Chapter 8, Section 5.1, paragraphs 2.5 and 2.6](#) for policy.

**3.7** Endovenous Radiofrequency Ablation (RFA)/obliteration (CPT<sup>2</sup> procedure codes 36475 and 36476) and endovenous laser ablation/therapy (CPT<sup>2</sup> procedure codes 36478 and 36479) for the treatment of saphenous venous reflux with symptomatic varicose veins **and/or incompetent perforator veins** is covered when:

**3.7.1** One of the following indications is present:

**3.7.1.1** Persistent symptoms interfering with activities of daily living in spite of conservative/non-surgical management. Symptoms include aching, cramping, burning, itching and/or swelling during activity or after prolonged standing.

**3.7.1.2** Significant recurrent attacks of superficial phlebitis.

**3.7.1.3** Hemorrhage from a ruptured varix.

**3.7.1.4** Ulceration from venous stasis where incompetent varices are a contributing factor.

---

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

## Abortions

Issue Date: April 19, 1983

Authority: [32 CFR 199.2\(b\)](#) and [32 CFR 199.4\(e\)\(2\)](#)

---

### 1.0 CPT<sup>1</sup> PROCEDURE CODE RANGE

59812 - 59857, 59866

### 2.0 HCPCS CODES

S0190, S0191, S0199

### 3.0 DESCRIPTION

Abortion means the intentional termination of a pregnancy by artificial means done for a purpose other than that of producing a live birth.

### 4.0 POLICY

**4.1** By law, abortions may not be cost-shared except:

**4.1.1** In a case in which the pregnancy is the result of an act of rape or incest. A physician's note in the patient's medical record must support that it is the provider's good faith belief, based on all of the information available to the provider, that the patient was the victim of rape or incest; or,

**4.1.2** When the life of the mother would be endangered if the fetus were carried to term. Physician certification attesting that the abortion was performed because the mother's life would have been endangered if the fetus were carried to term is required.

**4.2** Services and supplies related to spontaneous, missed or threatened abortions and abortions related to ectopic pregnancies may be cost-shared.

**4.3** All medically and psychologically necessary services and supplies related to a covered abortion are covered. This may include ultrasound performed prior to the abortion, pathology services, pregnancy tests, office visits, and any applicable requirements mandated by state and/or local laws. It also may include otherwise covered follow-up care, such as psychotherapy.

**4.4** Drugs such as Mifeprex (HCPCS S0190) and misoprostol (HCPCS S0191) may be cost-shared when the pregnancy is the result of an act of rape or incest.

---

<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

## 5.0 BILLING PROCEDURES

### 5.1 G7 Modifier

To receive TRICARE reimbursement for abortions performed due to rape, incest or when the life of the mother is endangered if the fetus were carried to term, all claims, i.e., the CMS 1450 UB-04 and the CMS 1500 shall include the G7 modifier. The G7 modifier is defined as "the pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening".

### 5.2 Condition Codes

To receive TRICARE reimbursement for abortions performed due to rape, incest or when the life of the mother is endangered if the fetus were carried to term, all claims, i.e., the CMS 1450 UB-04 and the CMS 1500 shall include one of the following condition codes:

- AA – Abortion performed due to rape,
- AB – Abortion performed due to incest,
- AD – Abortion performed due to life endangering physical condition.

### 5.3 Outpatient Billing (Hospital Outpatient Departments (HOPDs) and Freestanding Ambulatory Surgery centers (ASCs))

HOPDs and freestanding ASCs shall bill on the CMS 1450 UB-04 claim form. One of the condition codes in [paragraph 5.2](#) and the G7 modifier is required on the UB-04 claim form in addition to one of the following Current Procedural Terminology (CPT<sup>2</sup>) procedure codes: 59840, 59841, 59850-59852, 59855-59857, 59866.

### 5.4 Professional Billing

Individual professional providers shall bill on the CMS 1500 claim form. One of the condition codes in [paragraph 5.2](#) shall be listed in FL 10d and the G7 modifier in FL24D. The claim shall include one of the following CPT<sup>2</sup> procedure codes: 59840, 59841, 59850-59852, 59855-59857, 59866.

## 6.0 TRICARE ENCOUNTER DATA (TED)

All TED records submitted for covered abortions must include one of the following Special Processing Codes as appropriate:

- AE (abortion performed due to rape),
- AF (abortion performed due to incest); or
- AG (abortion performed due to life endangering physical condition).

## 7.0 EDUCATION REQUIREMENTS

The TRICARE Operations Manual (TOM), [Chapter 11, Section 1](#) provides the contractors' responsibility regarding education of providers and beneficiaries.

<sup>2</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.