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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 77
6010.55-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.55-M, issued August 2002.

CHANGE TITLE: AMA LICENSE AGREEMENT UPDATE

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates the footnote for the AMA
License Agreement for 2006 and future publications.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting
Officer.

This change is made in conjunction with Aug 2002 TOM, Change No. 65, Aug 2002
TPM, Change No. 78, and Aug 2002 TSM, Change No. 60.

David E. Bennett
for David E. Bennett
Acting Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 208 PAGE(S)
DISTRIBUTION: 6010.55-M

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

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ANESTHESIA

ISSUE DATE: August 26, 1985

AUTHORITY: [32 CFR 199.4\(c\)\(2\)\(vii\)](#), [\(c\)\(2\)\(viii\)](#), and [32 CFR 199.6\(c\)](#)

I. CPT¹ PROCEDURE CODE RANGE

00100 - 01999

II. APPLICABILITY

The policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

III. ISSUE

How is reimbursement for anesthesia services to be determined?

IV. POLICY

A. Procedure codes. Claims are to be billed using the CPT-4 anesthesia codes.

B. Payment. Payment is calculated by multiplying the applicable conversion factor by the appropriate number of base units plus time units for each code.

1. There are two conversion factors--one for physicians and one for non-physicians, and the conversion factors are adjusted by wage indexes for each locality. The locality-specific conversion factors are adjusted in the same manner applied to CMACs. That is, the current contractor-maintained conversion factors are compared to the Medicare locality-specific conversion factors, and the conversion factors are reduced a maximum of fifteen percent a year or to the Medicare level.

2. Base units for each procedure are derived from the Medicare Anesthesia Relative Value Guide. Time units are 15 minutes, and any fraction of a unit is considered a whole unit. Time units will be as submitted on the claim.

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C. Files provided to Contractors. Each year the contractors will receive a file which contains the conversion factors (two per locality) along with the number of base units per CPT-4 code.

D. Identification of provider. Since payment rates distinguish between physicians and non-physicians, each anesthesia claim must identify who provided the anesthesia. In those cases where part of the anesthesia service is provided by an anesthesiologist and the remainder by a **nonphysician** anesthetist, the claim(s) must identify exactly the services provided by each type of provider, so that the appropriate payment level can be used.

E. Anesthesia administered by Operating Surgeon. Administration of general anesthesia by the operating surgeon is not covered. If the surgeon bills a single charge which includes both the surgery and the anesthesia, a breakdown of the charge should be obtained and the anesthesia services denied. When a breakdown of charges is not available, payment will be based on the allowable charge for the surgery alone.

F. **Total payment. Generally the total amount allowed or anesthesia provided by an anesthesiologist and a nonphysician anesthetist cannot exceed what would have been allowed had the anesthesia been provided only by an anesthesiologist. In no case can it exceed that amount if the nonphysician anesthetist is an anesthesiologist assistant. If the nonphysician anesthetist is a certified registered nurse anesthetist, the total allowed amount can exceed that amount only if unusual circumstances warrant additional payment and those circumstances are documented in the medical record.**

- END -

POSTOPERATIVE PAIN MANAGEMENT

ISSUE DATE: February 21, 1995

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

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

How are physicians to be reimbursed for postoperative pain management?

III. BACKGROUND

A. In the past, postoperative pain management consisted mainly of the intramuscular (IM) and/or intravenous (IV) administration of patient controlled analgesia (PCA). The attending surgeon simply wrote an order in the patient's clinical chart/record which was later carried out by the floor nurse. This was considered a part of the global charge for the surgery.

B. Postoperative epidural analgesia care is a relatively new and progressive innovation in acute pain management. It provides superior pain management for major surgery by markedly decreasing the incidence of pulmonary and cardiovascular complications. The use of epidural analgesia also promotes earlier ambulation which decreases deep vein thrombosis, and promotes return of bowel functions. The administration of epidural analgesia is a specialized technique that can only be provided by a specially trained physician. It includes the following services:

1. Placement of the epidural catheter (an invasive procedure requiring about twenty minutes).
2. Mixing of the epidural analgesia infusion.
3. Programming and initiation of infusion pump.
4. Completion of detailed epidural analgesia orders.

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5. Daily monitoring and adjustment of epidural and infusion pump.

6. Twenty-four hour availability/coverage to physically respond to problems/complications.

C. Since postoperative epidural analgesia care represents a level of services above that of routine postoperative pain relief provided by physicians, it is allowed outside the global surgical fee subject to the following reimbursement guidelines.

IV. POLICY

A. Payment of postoperative pain management outside the global surgical fee is only allowed for epidural analgesia care provided and billed by a physician. TRICARE/CHAMPUS will pay the physician for:

1. Insertion of the epidural catheter (CPT¹ procedure codes 62278 and 62279 - epidural, lumbar or caudal, continuous) on the day of the surgery; and

2. Daily hospital management of epidural drug administration (CPT¹ procedure code 01996) following the day of surgery (not the day of surgery).

B. The physician is only allowed to bill one pain management procedure code (CPT¹ procedure code 01996) per day. The procedure includes all visits and contacts during the 24-hour time period to adjust the dosage and to maintain a functioning catheter.

C. Daily hospital management of epidural drug administration will be paid up to 3 days following the day of surgery. Additional management services may be allowed at the discretion of the contractor based on best commercial practices.

- END -

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3. When separate charges are billed for specific covered ALS services, allowable charge profiles for each such service should be developed. When a claim is filed for any one or a combination of such covered services, the maximum allowable charge for the total ambulance service will be the sum of the allowable amounts for the supplier's base rate, any mileage charges, and the specific specialized service(s). When the contractor does not have a profile for the specialized service, it may use the profile for an equivalent service as a guideline for determining an appropriate allowance. For example, if an ambulance supplier submits a separate additional charge for covered EKG monitoring and the contractor does not have a prevailing profile for such charges submitted by an ambulance supplier, the contractor may use the profiles for CPT¹ procedures codes 93012 and 93270 as guidelines for determining the allowable amount.

4. Although separate charges may be allowed for specific ALS services, no separate charge can be allowed for the personnel manning the ALS, even though they are obviously more highly qualified than the personnel in a basic ambulance. Their costs are to be included in the base and mileage charges with the exception of paramedic ALS intercept services (PI) under the following conditions:

a. Be furnished in an area that is designated as a rural area by any law or regulation of the State or that is located in a rural census tract of a metropolitan area.

b. Be furnished under contract with one or more volunteer ambulance services that meet the following conditions:

- (1) Are certified to furnish ambulance services;
- (2) Furnish services only at the BLS level; and
- (3) Are prohibited by State law from billing for any service.

c. Be furnished by a paramedic ALS intercept supplier that meets the following conditions:

- (1) Is certified to furnish ALS services.
- (2) Bills all the recipients who receive ALS intercept services for the entity, regardless of whether or not those recipients are Medicare beneficiaries.

C. The cost-sharing of ambulance services and supplies will be in accordance with the status of the patient at the time the covered services and supplies are rendered ([32 CFR 199.4\(a\)\(4\)](#)).

1. Ambulance transfers from a beneficiary's place of residence, accident scene, or other location to a civilian hospital, MTF, VA hospital, or SNF will be cost-shared on an outpatient basis. Transfers from a hospital or SNF to a patient's residence will also be considered an outpatient service for reimbursement under the program. A separate cost-

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share does not apply to ambulance transfers to or from a SNF, if the costs for ambulance transfer are included in the SNF PPS rate (see [Chapter 8, Section 2, paragraph IV.C.13.e.](#)).

2. Ambulance transfers between hospitals (acute care, general, and special hospitals; psychiatric hospitals; and long-term hospitals) and SNFs will be cost-shared on an inpatient basis. The following guidelines are consistent with the inpatient deductible and cost-sharing provisions provided in [Chapter 2, Section 1, paragraph I.B.](#) and [E.](#):

a. Deductible Amount Inpatient: None.

b. Cost-Share Amount Inpatient (Non-Network Providers).

(1) Active Duty Dependent: No cost-share is taken for ambulance services (transfers) rendered in conjunction with an inpatient stay.

(2) Other Beneficiary: The cost-share applicable to inpatient care for other than active duty dependent beneficiaries is twenty-five percent (25%) of the TRICARE/CHAMPUS-determined allowable amount.

3. Under the above provisions, for ambulance transfers between hospitals, a nonparticipating provider may bill the beneficiary the lower of the provider's billed charge or 115 percent of the TRICARE/CHAMPUS allowable charge.

4. Transfers to a MTF, VA hospital, or SNF after treatment at, or admission to, an emergency room or civilian hospital will be cost-shared on an inpatient basis, if ordered by either civilian or military personnel.

5. Medically necessary ambulance transfers from an emergency room (ER) to a hospital more capable of providing the required level of care will also be cost-shared on an inpatient basis.

NOTE: This is consistent with current policy of cost-sharing ER services as inpatient when an immediate inpatient admission for acute care follows the outpatient ER treatment.

IV. POLICY CONSIDERATIONS

A. Ambulance Membership Programs.

1. Ambulance membership programs typically charge an annual fee for a subscription to an ambulance service. The ambulance provider agrees to accept assignment on all benefits from third party payers for medically necessary services. By paying the annual fee, the covered family members pay no additional fees (including third party cost-shares and deductibles) to the ambulance service.

2. When a beneficiary pays premiums to a pre-paid ambulance plan, the premiums are considered to fulfill the beneficiary's cost-share and deductible requirements. Under this arrangement, the ambulance membership program becomes analogous to a limited supplemental plan.

ASSISTANT SURGEONS

ISSUE DATE: April 5, 1989

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

I. CPT ¹PROCEDURE CODES

10040 - 69990, 92982, 92984, 92995, 92996, 92998

II. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

III. ISSUE

How are assistant surgeons to be reimbursed?

IV. BACKGROUND

An assistant surgeon is a physician, dentist, podiatrist, certified physician assistant, nurse practitioner, or certified nurse midwife acting within the scope of their license, who actively assists the operating surgeon in the performance of a covered surgical service. Refer to [Chapter 1, Section 6](#) for information regarding reimbursement of certified physician assistants and nurse practitioners performing as assistant surgeons.

V. POLICY

A. Services of an assistant surgeon are payable when:

1. The surgical procedure is of such complexity and seriousness as to warrant an assistant surgeon. The assistant surgeon's services must be of the type that cannot be accomplished by operating room nurses or other such operating room personnel.

2. Interns, residents or other hospital staff are not available to provide the surgical assistance. This necessarily entails that the assistant be involved in the actual performance of the procedure, not simply in other, ancillary services. Since an assistant would, thus, be

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occupied during the surgical procedure, the assistant would not be available to perform (and thus, could not bill for) another surgical procedure during the same time period.

NOTE: Standby assistant surgeon services are not reimbursed when the assistant surgeon does not actively participate in the surgery.

B. The allowable charge for an assistant surgeon (where such services are covered) is to be the lower of the billed charge or 16 percent of the prevailing charge for the surgery involved. When an assistant surgeon is involved in multiple surgery, the same procedures used for determining reimbursement for the primary surgeon shall be used in determining reimbursement for the assistant surgeon.

VI. EFFECTIVE DATE

The 16 percent reimbursement methodology is effective for assistant surgeon services provided on or after November 1, 1993.

- END -

PROFESSIONAL SERVICES: OBSTETRICAL CARE

ISSUE DATE: August 26, 1985

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

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. POLICY

A. Obstetrical services are reimbursed as an all-inclusive global maternity professional fee which includes all professional services normally provided for routine antepartum care, vaginal delivery (with or without episiotomy, or forceps or breech delivery) and postpartum care.

B. The price for total (all-inclusive; global) obstetric care includes all attending physician or attending certified nurse-midwife services required during the course of the maternity episode. Incidental activity (observation, preparation, coordination, administration) rendered by office staff in support of the obstetrical professional's delivery of services are included in the price.

III. EXCEPTIONS

A. Hospital-employed provider. Line item charges for covered obstetrical services of a physician or certified nurse-midwife employed by (1) a DRG-exempt hospital is reimbursed on a billed-charge basis; by (2) a DRG hospital is reimbursed subject to the TRICARE/CHAMPUS-determined maximum allowable charge.

B. Partial care rendered. Separate billings for antepartum care or delivery or postpartum care may be reimbursed subject to the aggregate amount limitations for a given segment of care prescribed in [paragraph V.B.](#) (LIMITATIONS) below.

C. Tests.

1. Technical component of tests. A separate allowance in addition to the global fee, subject to the appropriate area prevailing profile, may be made for the technical component of medically necessary tests provided during the period of maternity care.

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2. Test-related professional charges. A legitimate consultation for the examination, analysis, interpretation, or application of diagnostic or laboratory test results by a professional other than the attending obstetrician or attending certified nurse midwife shall not be considered as included in the obstetric global fee.

D. Pregnancy testing. A separate allowance in addition to the global fee may be made for diagnostic tests for determination of a pregnant condition. The test may be cost-shared regardless of the outcome of the test.

E. Extraordinary professional services.

1. A separate allowance in addition to the global fee, subject to the appropriate area prevailing profile, may be made for professional services in excess of the quantity usually associated with a normal pregnancy and delivery when the extraordinary services are not otherwise excluded by the contractor's medical review. The rationale for reimbursement of these cases must be fully documented by the contractor.

2. Medically necessary antepartum office visits in excess of a total number of antepartum visits equal to twelve (12) visits plus one (1) weekly visit from the 37th week of gestation through delivery, may be considered for an additional allowance only when the contractor's medical review confirms documented maternal or fetal risk factors which required special management, or complications of pregnancy.

3. Medically necessary postpartum office visits in excess of two (2) may be considered for an additional allowance only for the management of a complication of pregnancy.

IV. POLICY CONSIDERATIONS

A. CPT¹ procedure codes 59400 or 59510 (total care; all-inclusive care; global care)

1. CPT¹ procedure codes 59400 or 59510 may be allowed only if the billing individual professional provider, or an alternate supervised by that provider, provided all segments of maternity care (antepartum care, delivery and postpartum care).

2. Natural childbirth classes and training may be allowed only when included in the charge for CPT¹ procedure code 59400 (all-inclusive care).

3. Charges for global care with and without natural childbirth classes and training should be included in the prevailing charge database for CPT¹ procedure code 59400.

B. Billing. Charges for the technical and professional components of tests must be separately identified on the maternity care bill and the number of antepartum and postpartum office visits must be indicated.

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C. Birthing center professional services. Reimbursement for professional services for maternity care and childbirth furnished by a TRICARE-authorized birthing center is included in the birthing center all-inclusive rate.

NOTE: The TRICARE/CHAMPUS national allowable charge system used to reimburse professional services discussed in [Chapter 1, Section 1](#), [Chapter 5, Section 1](#), and [Chapter 5, Section 3](#) does not apply to birthing center claims. The reimbursement guidelines as discussed in the TRICARE Policy Manual, [Chapter 11, Section 3.1](#) are to be used by the contractors.

D. Discontinue use of CPT² procedure code 59421. CPT² procedure code 59421 should not be used to report any maternity care rendered after March 31, 1989. CPT² procedure code 59420 shall be used to report individual antepartum services rendered March 31, 1989 through December 31, 1992. CPT² procedure code 59420 was deleted effective with Current Procedural Terminology 1993. There is no code for the entire antepartum episode after March 31, 1989.

E. The LIMITATION that interim billings from a single individual professional provider or separate billings from different individual professional providers were subject to an aggregate maximum amount determined as a percentage of the price for CPT² procedure code 59400 was removed effective with Revision number 7.

V. LIMITATIONS

A. The billing of separate maternity care procedures is subject to rebundling to CPT² procedure codes 59400 or 59510 when all-inclusive maternity care was provided by the same professional provider. See also: [Chapter 1, Section 3](#), [Rebundling Of Procedure Codes](#).

B. Office-based childbirth services. The allowable charge for all-inclusive maternity care and childbirth in a physician's office or in a certified nurse-midwife's office is limited to the established allowable-charge for professional services for all-inclusive maternity care plus the allowable-charges for supplies usually associated with an in-home delivery.

VI. EXCLUSIONS

A. The following procedures² are excluded when billed separately:

99071	PATIENT EDUCATION MATERIALS
99078	GROUP HEALTH EDUCATION

B. No technical component of a diagnostic or laboratory test is included in the total obstetric care price.

C. Test-related charges by the attending professional. With the exception of medically necessary ultrasounds, no separate allowance may be made for the examination, analysis, interpretation, or application of diagnostic or laboratory test results by the attending obstetrician or attending certified nurse-midwife. These activities are considered to be the

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responsibility of the attending professional and included in the global fee of the attending obstetrical care professional. For maternity related ultrasounds, see the TRICARE Policy Manual, [Chapter 5, Section 2.1](#).

- END -

STATE AGENCY BILLING

ISSUE DATE: June 1, 1999

AUTHORITY: [32 CFR 199.8](#)

I. DESCRIPTION

General: When a beneficiary is eligible for both TRICARE and Medicaid, [32 CFR 199.8](#) establishes TRICARE as the primary payor. To implement this provision, the contractor shall arrange coordination of benefits procedures with the various states to facilitate the flow of claims and to try to achieve a reduction in the amount of effort required to reimburse the states for the funds they erroneously disbursed on behalf of the TRICARE-eligible beneficiary. Such bills may be signed by authorized state officials and do not require a separate signature of either the beneficiary or the provider. The contractor should make disbursement directly to the state agency (or contractor acting as the agent for the state agency), following established TRICARE claims processing guidelines and requirements (see the TRICARE Operations Manual ([TOM](#)), [Chapter 8](#)). The contractor will verify the signatures under the same rules and criteria as exist for verification of provider facsimile or authorized representative signatures (see the [TOM](#), [Chapter 8, Section 5](#)). Medicaid claims are subject to normal claims processing requirements for establishment of eligibility.

II. POLICY

A. Claims Processing Requirements/Exceptions

1. Claims Submission Procedures

a. The state agency is responsible for submission of the claim in a form/format acceptable to the contractor. For example, the state must submit claims on an acceptable claim form, and attach a computer printout of the state's record of the services and/or copies of the original bills. All required processing data must be submitted in an acceptable format. When the state and the contractor have the capability to exchange the data for claims processing in an electronic format, this shall be defined and included in the agreement between the MCS contractor and the state.

b. Each batch of claims (if each claim is not individually signed) must be certified by an authorized state official (or contracted agent acting for an authorized state official) as accurate. A covering transmittal document that identifies the claims covered by the certification must accompany each batch of claims. The patient names and sponsor SSNs must also be included on the transmittal certification. For audit trail purposes, the contractor shall enter the Julian calendar date of receipt on the transmittal document and ensure that all

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included claims also receive the same Julian calendar date in the Internal Control Number (ICN).

c. The transmittal documents shall be retained in a readily accessible file or may be microcopied with the claims, if the contractor is microfilming its claims at the front end of its processing system.

2. Claims Adjudication

Except for the following, claims submitted by state agencies are subject to all applicable TRICARE requirements, limitations and definitions.

CONDITION	PROCEDURE
Durable Medical Equipment - Prescriptions Missing	Do not develop for this information unless there is no reasonable correlation between the diagnosis and the equipment on the claim. If the diagnosis is missing and there is no documentation on file to support the claim, return the claim for supporting diagnosis or prescription. Amount of payment will follow the basic guidelines of Chapter 1, Section 11 . As a general rule, if the state is paying rental on the equipment, TRICARE will pay the rental. If the state has paid for purchase, assume that to be cost advantageous and reimburse the state accordingly.
No COB Information	Waive if the state coordinates. Accept the certification from the authorized state official for documentation that, in absence of other insurance information (OHI), there is no known OHI. If other insurance is present, it is necessary to know the amount paid by the OHI to properly reimburse the state for the amount they have actually paid, but not to exceed the amount TRICARE would have paid. If the contractor detects that OHI does exist, processing will be terminated and the claim will be returned to the state agency for action. It is the state agency's responsibility to determine if an error has been made in submission or if the patient or provider may have committed a fraudulent act.
Lack of itemization on inpatient hospital bills; i.e., hospital detail is lacking	Beginning and ending dates of hospital stay are required. Breakdown of detailed services and supplies must be detailed enough to determine the Revenue Code major category. Contractors may assume the charges are for a semi-private room, in absence of evidence to the contrary, and report with Revenue Code "12X." In every instance, the Revenue Code in the Institutional Record must crossfoot as required by the TRICARE Systems Manual, Chapter 2 , Sections 3 through Chapter 8. Waiver of the requirement to develop for the breakdown of services does not excuse the contractor from coding the detail which is present on the claim.

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CONDITION	PROCEDURE
No breakdown of service detail; e.g., multiple office visits or multiple lab services, etc.	Waive: For TEDs, the contractor is authorized to estimate frequency of the charge by using a reasonable approximation. For example, June 1 - 8, CPT ¹ procedure code 90050 with a \$57.00 charge. Assume two office visits @ \$28.50.
Quantity, strength, etc., missing on drug claims.	Waive: Pay as billed and assume that the state agency has a control system in place. If evidence develops to refute this assumption, contact the state agency for development of appropriate controls. Process drug claims from state agencies as if they were consolidated drug claims.
Diagnosis Missing	<u>Waive</u> on office visits (unless services appear to be for a routine physical or related to other excluded services); consultations; drugs; lab; x-ray; assistant surgeon and anesthesiology. Use ICD code 799.9 in absence of a correct code.
Diagnosis Missing	<u>Require</u> on hospital, surgery and mental health. For DME, if the record provides information other than a diagnosis which can reasonably support the payment, proceed. Return the incomplete claim, which requires a diagnosis, to the state for supporting information.
Timely filing limits.	The state must file no later than one year following the date of service of the date of discharge if the services were rendered during an inpatient admission. For waivers, see the TOM, Chapter 8, Section 4, paragraph 2.0.
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3. TED Reporting of State Agency Claims

Claims received for state agencies will be processed with the Special Processing Code '1' on TEDs (see the TRICARE Systems Manual, [Chapter 2](#)). The reimbursement amounts the other TED coding will follow the basic requirements for a participating claim with the state Medicaid agency designated as the payee. The amount paid by the government must be reported in the Amount Paid by Government Contractor field.

4. Development with State Agencies

States are obligated to provide the data needed to process the claims they submit, including eligibility and other beneficiary information. In some cases, the contractor will need to develop data through DEERS or other in-house information to accurately process the claim. For other required data, or in case of failure to locate essential information, the contractor will return the claim to the state agency. If a state routinely fails to submit required data on its claims, the contractor shall contact the state agency and request cooperation. TMA shall be advised of any such problems and the results of any contacts.

5. Duplicate Checking

Contractors are expected to ensure that precautions are taken to prevent duplicate payments, as provided in the TOM, Chapter 8, Section 9. In cases where the exact type of service data has not been provided, but a duplication of types of service is apparent; e.g., apparent duplication of lab and office services, the contractor shall attempt to resolve the case with the data available in-house. If the matter cannot be resolved, assume duplication and deny the claim. If the state agency has information to the contrary, it may resubmit with the necessary documentation to refute the assumption. If a beneficiary or provider has submitted claims for services directly to TRICARE and the same services have also been sent to the state for Medicaid payment, the possibility of fraud must be considered. Since the patient would have been TRICARE-eligible, any fraud would have been an offense against the state program. Return the claim to the state agency and advise them of the facts including that payment has been made by TRICARE. The contractor shall cooperate in any state investigation to the extent possible under TRICARE guidelines. In any case of doubt about what information can be released in an investigation, contact TMA for instructions.

6. Nonavailability Statement (NAS)

The state must include the address of the beneficiary on the claim and the contractor will verify whether a Nonavailability Statement is required, using normal processing rules, including a check of the related history files to determine if an NAS is on file. If an NAS is required, and none is available, the claim will be denied and the State Medicaid Agency notified on the EOB. No further action is required by the contractor.

7. Providers

Providers must be TRICARE-approved or TRICARE-eligible in accordance with the TOM, Chapter 2. If the provider named on the claim is not on the contractor provider files, but is in a category which is normally acceptable under TRICARE; e.g., a physician, psychologist, hospital, etc., the contractor shall follow normal procedures to certify. If the provider is not in a certifiable category under the contract, return the claim to the state.

8. Third Party Liability (TPL)

When submitting claims to TRICARE for recovery of payments made, the state agency should attach information regarding possible "Third Party Liability" (TPL) for those claims which carry a diagnosis requiring development (see the TOM, Chapter 11). However, if the TPL data submitted is not adequate to provide all the information required, return the claim to the state agency to obtain the necessary information. It is expected that the state agency will have a fully developed file to establish or to rule out possible TPL. If TPL is involved, the state should have exercised its subrogation rights and the state's beneficiary claim file should reflect complete data, including the amount paid under TPL. Where TPL does exist, the TRICARE claim liability should be minimal. The contractor should not contact the beneficiary or the provider(s).

B. Reimbursement Procedures and Requirements

The contractor shall reimburse the State Medicaid Agency (or contractor acting as the

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agent for the state Medicaid agency) directly for all claims submitted by the agency using an EOB for each claim, unless arrangements and agreement between the contractor and the state agency provide for a summary payment voucher. No EOB or other notice will be sent to either the beneficiary or the provider. The allowance determination will be based on the amount billed to the Medicaid Agency by the provider of care. The contractor shall calculate the net amount which would have been payable by TRICARE including, when appropriate, the COB reduction, deductible and cost-share amounts in the determination. The state will be paid the lesser of the amount it actually paid or the amount that TRICARE would have paid. The Medicaid billing by a provider is frequently less than the provider's customary charge. These charges will not be included in the determination of the prevailing charges for an area. If a provider of care subsequently bills, requesting payment for the difference between the Medicaid payment and the amount customarily billed, the claim shall be denied as a duplicate. No additional payment will be made. If a service which would be allowable by TRICARE has been denied by Medicaid and is subsequently submitted by a provider of care, the charge shall be considered as any other claim.

- END -

duty in support of operations that result from the terrorist attacks on the World Trade Center and the Pentagon on September 11, 2001.

(2) The cost-share is partially waived in certain cases for these beneficiaries. On claims from non-participating professional providers for services rendered to Standard beneficiaries, the allowable amount is the lesser of the billed charge or the balance billing limit (115%) of the CMAC. In these cases, the cost-share is 20% of the lesser of the CMAC or the billed charge, and the cost-share for any amounts over the CMAC that are allowed is waived. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

(3) The exception to the deductible and cost-share requirements under Operation Noble Eagle/Operation Enduring Freedom for TRICARE Standard and Extra is effective for services rendered from September 14, 2001, through October 31, 2008.

d. For Certain Reservists. The Director, TRICARE Management Activity, may waive the individual or family deductible for dependents of a reserve component member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a reserve component member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 U.S.C. 101(a)(13). Also, for this purpose a dependent is a lawful husband or wife of the member or an eligible child.

B. TRICARE Prime.

1. Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See [Chapter 2, Addendum A](#) for additional information on the benefits and costs. In accordance with Section 752 of the National Defense Authorization Act, P.L. 106-398, for services provided on or after April 1, 2001, a \$0 copayment shall be charged to TRICARE Prime ADFMs of active duty service members (ADSMs) who are enrolled in TRICARE Prime. Pharmacy copayments and Point of Service charges are not waived by the FY01 Authorization Act.

2. In instances where the CMAC or allowable charge is less than the copayment shown on [Addendum A](#), network providers may only collect the lower of the allowable charge or the applicable copayment.

3. The TRICARE Prime copayment requirement for emergency room services is on a PER VISIT basis; this means that only one copayment is applicable to the entire emergency room episode, regardless of the number of providers involved in the patient's care and regardless of their status as network providers.

4. No copayments or authorizations are required for TRICARE Prime clinical preventive services which are described in the TPM, [Chapter 7, Section 2.2](#).

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CHAPTER 2, SECTION 1 COST-SHARES AND DEDUCTIBLES

5. Effective for care provided on or after March 26, 1998, Prime enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply):

a. Diagnostic radiology and ultrasound services included in the CPT¹ procedure code range from 70000 through 76999, or any other code for associated contrast media;

b. Diagnostic nuclear medicine services included in the CPT¹ procedure code range from 78000 through 78999;

c. Pathology and laboratory services included in the CPT¹ procedure code range from 80000 through 89399; and

d. Cardiovascular studies included in the CPT¹ procedure code range from 93000 through 93350.

e. Venipuncture included in the CPT¹ procedure code range from 36400 - 36416.

f. Fetal monitoring for CPT¹ procedure codes 59020, 59025, and 59050.

NOTE: Contractors are not required to search their files for claims for ancillary services which were not processed according to these guidelines. The contractor shall, however, if requested by an appropriate individual, adjust specific claims under these guidelines if the date of service is on or after March 26, 1998.

6. Point of Service (POS) option. See [Chapter 2, Section 3](#).

C. Basic Program: TRICARE Standard.

1. Deductible Amount: Outpatient Care.

a. For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(1) Deductible, Individual: Each beneficiary is liable for the first fifty dollars (\$50.00) of the TRICARE-determined allowable amount on claims for care provided in the same fiscal year.

(2) Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars (\$100.00).

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b. The summary data used to develop prevailing conversion factors. This is to include every prevailing charge (identified by amount, procedures, weighted frequency, and relative value units) which was used in calculating each conversion factor.

B. Data Base And Profile Updating

1. The 80th percentile of charges shall be determined on a date or dates specified by the Executive Director, TMA. Profile update data used shall be charges for services and supplies provided during the 12 month period ending on June 30 prior to the update. Contractors shall maintain two sets of profiles; the current profiles and the previous year's profiles. The contractor will apply profiles based on the date of service. The fee screen year is the calendar year.

2. Each contractor shall develop procedures to ensure that the data base used to develop the profile for any procedure contains only charges actually made for that procedure. Thus, edits must be developed which will eliminate charges for individual consideration cases, and charges for multiple surgery, as well as aberrant data resulting from coding errors and other data problems. A description of these procedures is to be available for TMA review.

3. All charges, except those identified above, made by individual providers for services rendered to TRICARE beneficiaries during the data base period must be included in the data base. The usual (pre-discount) charges of network providers or the contractor's or a subcontractor's private business may be included if the billing arrangement with the provider or other source of data for the data base is such that accurate data for the state will be obtained.

4. Except when an error has occurred, updated actual prevailings are not to be lower than the previous year's actual prevailings. However, if for two consecutive years the rates are lower than the established profiles, then, in the second year, the rates will be lowered to the higher of the two profiles which are below the established profile. However, if the updated prevailing charge is lower, contractors are to continue using the previous actual prevailing charge. When the updated prevailing charge is 25% or more lower than the previous prevailing charge, the contractor is to review the development of both profiles. If no errors are found, the new profile is to be increased to the level of the previous profile. If the previous profile is higher due to an error in its calculation, the updated profile will be used. The same rules apply to conversion factors when the updated conversion factor is less than the previous one. However, in all cases an actual profile on a procedure takes precedence over an allowance based on a conversion factor.

a. When the current allowance based on a conversion factor is less than the previous allowance based on an actual profile, the previous profile amount is to be used.

b. When the current allowance based on an actual profile is less than the previous allowance based on a conversion factor, the actual profile is to be used.

NOTE: This provision does not apply to those instances where profiles are initially developed for a distinct class of provider which was previously included with providers having higher profiles.

5. Once the contractor has completed the update of its profiles, further revisions in the profiles will not be permitted, except to correct erroneous calculations or to establish profiles for new services. If the contractor finds it necessary to correct profiles or to establish a profile fee for a new procedure, the action will be thoroughly documented and retained in accessible form for not less than the retention period for the claims processed during the active life of that profile.

C. Prevailing Charges

1. Prevailing charges are those charges which fall within the range of charges that are most frequently used in a state for a particular procedure or service. The top of this range establishes an overall limitation on the charges which the contractor shall accept as allowable for a given procedure or service, except when unusual circumstances or medical complications warrant an additional charge (see [Chapter 5, Section 4](#)).

2. Unless the Executive Director, TMA, has made a specific exception, prevailing profiles must be developed on a statewide basis. Localities within states are not to be used, nor are prevailing profiles to be developed for any area larger than individual states.

3. Prevailing profiles also are to be developed on a nonspecialty basis. Of course, types of service are to be differentiated. For example, for a given surgical procedure the surgeon, assistant surgeon, and the anesthesiologist would all be reimbursed based on different profiles. However, reimbursement for the actual surgery would be based on only one profile, regardless of whether the surgery was performed by a specialist or a general surgeon. An exception to this rule is that when services are performed by different classes of providers; e.g., a physician vis-a-vis a non-physician, separate profiles are to be developed for each class of provider. For example, there are three distinct classes of providers who render similar psychiatric services; psychiatrists, psychologists and others (Masters of Social Workers (MSWs), marriage and family counselors, pastoral counselors, mental health counselors, etc.). Moreover, two distinct classes of providers render obstetrical services; physicians and nurse midwives. Separate profiles are to be developed for each of the classes. Since a physician can render more comprehensive services than non-physicians (and likewise for psychologists as opposed to MSWs) the profile for the lesser-qualified class of provider should never be higher than that for a higher-qualified class of provider. For example, in cases in which psychologists' profiles are higher than psychiatrists', the psychologists' profiles should be lowered to that of the psychiatrists' profiles.

4. When there are two or more procedures which are identical except for the amount of time involved (e.g., CPT¹ procedure codes 90843 and 90844), the contractor is to ensure that the profile for the shorter procedure does not exceed the profile for the longer procedure. In those cases in which it does, the contractor is to reduce the profile for the shorter procedure to that of the longer procedure (see [Chapter 5, Section 3](#)).

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D. Conversion Factors

1. General

Submitted charges must be compared with the applicable prevailing charge to determine the allowable charge for the service. If there is insufficient actual charge data to determine the prevailing charge in the state for a service, the contractor shall calculate a prevailing charge by multiplying the appropriate prevailing charge conversion factor by the appropriate relative value units.

a. Conversion factors are to be developed for broad types of services. As a minimum, the types of service shall include medicine, surgery, anesthesia, radiology, and pathology. In addition, separate conversion factors must be developed for each class of provider which can provide a particular type of service. For example, there should be three medicine conversion factors - one for physicians, one for psychologists, and one for other non-physician providers.

b. Conversion factors are used to derive "approximate" prevailing charges. Since prevailing charges based on conversion factors are estimates of actual (but unknown) "average" charges, their reliability is only as good as the known, but often limited, data. Contractors must exercise extreme care in developing conversion factors. When beneficiaries, physicians, and suppliers inquire regarding reimbursement based on the use of a conversion factor, the contractor shall use its best judgment based on the data available to it (including information the physician or supplier may furnish) to resolve the issue.

c. In those cases in which a profile has been increased to the previous year's level, the contractor shall also use the higher previous amount in calculating a conversion factor. A conversion factor is simply a mathematical representation of what is currently being paid for similar services, and thus it should be based on the profiles actually in use.

2. Relative Value Scales

Relative value scales developed or adopted by the contractor shall be carefully reviewed and validated before they are used. The contractor is responsible for ensuring that a relative value scale which is used to estimate prevailing charges accurately reflects charge patterns in the area serviced by the contractor. When a conversion factor results in an obviously incorrect amount (either high or low), the contractor is to make an adjustment in its relative value scale which will correct the error. Such corrections are to be reviewed in subsequent profile updates to ensure they are accurate.

3. Calculation Of Prevailing Charge Conversion Factors

a. Prevailing charge conversion factors used with relative value scales to fill gaps in contractor prevailing charge screens shall be calculated from the following formula:

C/F = Prevailing charge conversion factor.
CHG = The fully adjusted prevailing charge for a procedure.

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SVC	= The number of times the procedure was performed by all physicians in the state.
RVU	= The relative value unit assigned to the procedure.
SUM OF SVC	= The total number of times all procedures for which actual prevailing charges have been established and were performed in the state.
C/F	= $\frac{\text{CHG} \times \text{SVC} + \frac{\text{CHG}}{\text{RVU}} \times \text{SVC} + \dots + \frac{\text{CHG}}{\text{RVU}} \times \text{SVC}}{\text{Sum of SVC}}$

EXAMPLE: Compute a prevailing charge conversion factor on the basis of known prevailing charges within the same type of service.

PROCEDURE	FREQUENCY	ACTUAL CHARGE	RELATIVE VALUE
1	30	\$5.00	1
2	70	12.00	2
3	50	35.00	5
4	40	20.00	3
5	<u>60</u> 250	8.00	1.5

b. Method

(1) For each procedure, divide the prevailing charge by the relative value and multiply the result by the frequency of that procedure in the charge history.

(2) Add all the results of these computations.

(3) Divide the result by the sum of all the frequencies.

c. Solution

$$\frac{(5 \times 30)}{1} + \frac{(12 \times 70)}{2} + \frac{(35 \times 50)}{5} + \frac{(20 \times 40)}{3} = \frac{(8 \times 60)}{1.5} =$$

250

$$(5 \times 30) + (6 \times 70) + (7 \times 50) + (6.67 \times 40) = (5.33 \times 60) =$$

250

$$150 + 420 + 350 + 266.8 + 319.8 =$$

250

$$\frac{1506.6}{250} = \$6.03$$

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d. The conversion factors calculated for any profile year shall reflect prevailing charges calculated on the basis of charge data for the applicable profile year. Also, prevailing charges established through the use of a relative value scale and conversion factors, in effect, consist of two components. Consequently, the conversion factors used must be recalculated when there is an extensive change in the relative value units assigned to procedures (as may occur if the contractor begins to use a different or updated relative value scale but not if the unit value of a single procedure is changed) in order to ensure that the change(s) in unit values do not change resultant conversion factors.

e. Since conversion factors are a calculated amount and will only be used when multiplied by a relative value, conversion factors are to be rounded only to the nearest whole cent. It will not be acceptable to round to the nearest dollar or tenth dollar (dime).

E. Procedure Codes. The CPT² Coding System includes Level I: CPT Codes and Level II: Alpha Character and TMA approved codes for retail and mail order pharmacy. (Reference the TRICARE Systems Manual (TSM), [Chapter 2, Addendum E and F.](#))

F. Professional surgical procedures will be subject to the same multiple procedure discounting guidelines and modifier requirements as prescribed under the Outpatient Prospective Payment System (OPPS) for services rendered on or after implementation of OPPS. Refer to [Chapter 1, Section 16, paragraph III.A.1.a. through c.](#) and [Chapter 13, Section 3, paragraph III.A.5.b. and c.](#) for further detail.

G. Professional procedures which are terminated or are bilateral will be subject to discounting based on modifier guideline requirements as prescribed under the OPPS for services rendered on or after implementation of OPPS. Refer to [Chapter 1, Section 16, paragraph III.A.1.a. through c.](#) and [Chapter 13, Section 3, paragraph III.A.5.b. and c.](#) for further detail.

H. Prevention Of Gross Dollar Errors. Parameters Consistent With Private Business. The contractor shall establish procedures for the review and authorization of payment for all claims exceeding a predetermined dollar amount. These authorization schedules shall be consistent with the contractor's private business standards.

III. ALLOWABLE CHARGE METHOD: APPLICATION

A. Durable Medical Equipment (DME), Durable Equipment (DE), And Supplies. Also, see [Chapter 1, Section 11](#) and the TRICARE Policy Manual (TPM), [Chapter 8, Section 2.1.](#)

B. Physician Assistant Services. The allowable charge for physician assistant services is determined in accordance with the provisions of [Chapter 1, Section 6](#), and is based on a percentage of the allowed charge for the service when performed by the employing physician. Only the employing physician may bill for physician assistant services. Physician assistants' billed and allowed charges must be excluded from calculation of physician

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profiles. Payment is made to the employing physician who is an authorized TRICARE provider.

C. Teaching Physicians. Payment for services of teaching physicians may be made on an allowable charge basis only if an attending physician relationship has been established between the teaching physician and the patient. Refer to [Chapter 1, Section 4](#) for a full explanation of applicable prerequisites.

IV. ALTERNATIVE REIMBURSEMENT METHODS FOR NON-NETWORK PROVIDERS

The contractor, with the concurrence of the Executive Director, TMA (or a designee), may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to assure a high level of acceptance of the TRICARE-determined charge by the individual health care professionals or other non-institutional health care providers furnishing services and supplies to TRICARE beneficiaries. Alternative methods shall not result in reimbursement greater than under the allowable charge method above, nor result in a higher cost for the affected beneficiary population.

V. CHAMPUS MAXIMUM ALLOWABLE CHARGE SYSTEM

A. General. The CHAMPUS Maximum Allowable Charge (CMAC) System is effective for services rendered on and after May 1, 1992. Contractors shall process claims using the requirements specified in the TRICARE Policy Manual (specific TRICARE Policy Manual references follow). Adjustments shall be processed using the reimbursement system in place at the time the services were rendered. The zip code where the service was rendered determines the locality code to be used in determining the allowable charge under CMAC. In most instances the zip code used to determine locality code will be the zip code of the provider's office. For processing an adjustment on a claim which was reimbursed using CMAC, the zip code which was used to process the initial claim must be used to determine the locality for the allowable charge calculation for the adjustment. Adjustments shall be processed using the appropriate fee screen year, which shall be based on the date of service. Post Office Box zip codes are acceptable only for Puerto Rico and for providers whose major specialty is anesthesiology, radiology or pathology (see [Chapter 5, Section 3](#)).

B. Locality Code. For TED reporting, the locality code used in the reimbursement of the procedure code is to be reported for each payment record line item, i.e., on each line item where payment is based on a CMAC, the locality shall be reported. Any adjustment to a claim originally paid under CMAC without a locality code, shall include the locality code that it was priced on at the time of the initial payment. The locality code reported on the initial claim shall be used to process any future adjustments of that claim unless one of the conditions listed below occurs:

1. The adjustment is changing the type of pricing from CMAC to state prevailing in which case the locality code should be blank filled, or;

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2. The initial claim was priced incorrectly because of using a wrong locality code, in which case the correct locality code should be used.

VI. BONUS PAYMENTS IN MEDICALLY UNDERSERVED AREAS

A. An additional payment shall be made quarterly to physicians who qualify and provide services in medically underserved areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)]. To initiate action for the additional payment, providers shall use modifiers that will signify the provider is requesting the additional payment. The modifiers are "QU" (urban HPSA), "QB" [rural HPSA], and "AR" [PSA bonus payment]. "QU", "QB" and "AR" are modifiers to the CPT/HCPCS procedure codes. The provider shall be paid an additional 10% HPSA bonus of the total amount paid, excluding interest payments, for claims that were processed during the calendar quarter for services rendered on or after June 1, 2003. The provider shall be paid an additional five percent PSA bonus of the total amount paid, excluding interest payment, for claims that were processed during the calendar quarter for services rendered on or after January 1, 2005. The contractor shall have 30 calendar days from the end of the calendar quarter to make the payments to the providers who qualify. The bonus payments could be paid to network, non-network, participating, or non-participating physicians. Special programs such as TPR, SHCP, and TSP shall be included in the bonus payment process. Contractors shall send bonus payments directly to the non-participating physician. Contractors shall report these claims on TEDs as required by the TSM, [Chapter 2, Section 2.7](#) (Procedure Code Modifiers). See [Chapter 1, Section 33](#) for additional information.

NOTE: Effective January 1, 2006, for services rendered on or after this date, the "QU" and "QB" modifiers shall be replaced with modifier "AQ".

1. The contractor is to inform providers of the PSA and HPSA bonus payments through stuffers and their quarterly news bulletin. The stuffers and bulletin should provide direction on what is required in order to obtain the bonus payment.

2. Basis of bonus payments to TRICARE-authorized providers is solely when a "AQ", "QU", "QB", or "AR" modifier is found on the claim.

B. Bonus payments are passthrough payments, non-financially underwritten payments. The contractor shall follow the process below. This process is similar to the payment of capital and direct medical education found under the DRG reimbursement system (see [Chapter 3, Section 2, paragraph II](#)).

1. All bonus payments are non-financially underwritten and shall be made from the non-financially underwritten, bank account (see the TRICARE Operations Manual (TOM), [Chapter 3, Section 2](#)).

2. Bonus Payment Procedures. The contractor shall use the following procedures in making bonus payments to physicians:

a. Accumulate and tally claims paid with "QU", "QB", or "AR" modifiers.

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b. Compute the amount due each physician for submitted claims during the calendar quarter for HPSA services rendered on or after June 1, 2003 and PSA services rendered on or after January 1, 2005. The PSA bonus only goes through June 30, 2008. Stop processing prior to check writing. Compute the total amount due all physicians. For services with both a professional and technical component, only the professional component would be included in the calculation of the bonus payment. The amount due is computed from claims with the "QU", "QB" and "AR" modifiers, then based on the amount paid (see [paragraph VI.B.3.d.](#)).

c. Any interest payments shall not be included in the computation of the payable bonus amount.

d. On the first work day of the last week of the month following the quarter, submit a voucher (see [paragraph VI.B.3.](#)) by express mail to TMA, CRM (a fax copy is not necessary).

e. After receiving clearance from TMA, CRM, continue processing through check write and mail out checks within two work days.

3. Vouchers

a. Format

- Physician Name
- Physician Address
- Physician Provider Number
- Period Covered (Quarter)
- Amount Paid/Collected for Bonus (see [paragraph VI.B.3.d.](#))
- Total Bonus Paid [5 and/or 10% of the above bullet]

b. Sort Bonus Payment

- By Type (e.g., standard or active duty)
- By Coverage (Prime, Extra, Standard)
- By Fiscal Year of Bank Account
- By Contract
- By City & State
- By Region
- By Physician
- By Physician Number
- By Specialty
- By Address & Zip
- By Participating & Non-Participating
- By Contracted (Network) and Not Contracted (Non-network)
- By Modifier ("QB", "QU" or "AR")

c. The contractor's worksheet showing the payment computation shall be attached to the quarterly voucher for each physician.

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d. In general:

Bonus Payment = 5% or 10% x [Total Amount Paid (claims with "QB" and "QU" modifiers or claims with "AR" modifier) During the Quarter - Interest Payments Associated with the claims for the Bonus Payment]

VII. BALANCE BILLING LIMITATION FOR NON-PARTICIPATING PROVIDERS

A. General

For services provided on or after November 1, 1993, non-participating providers may not balance bill the beneficiary more than 115% of the allowable charge.

NOTE: When the billed amount is less than 115% of the allowed amount, the provider is limited to billing the billed charge to the beneficiary. The balance billing limit is to be applied to each line item on a claim.

EXAMPLE 1: No Other Health Insurance

Billed charge	\$500
Allowable charge	\$200
Amount billed to beneficiary (115% of \$200)	\$230

EXAMPLE 2: Other Health Insurance

Billed charge	\$500
Allowable charge	\$200
Amount paid by other health insurance to the beneficiary	\$200
Amount billable to beneficiary (115% of \$200)	\$230

NOTE: When payment is made by other health insurance, this payment does not affect the amount billable to the beneficiary by the non-participating provider except, when it can be determined, that the other health insurance limits the amount that can be billed to the beneficiary by the provider.

EXAMPLE 3: Provider Refuses To File Claim Or Has Charged An Administrative Fee

Billed charge	\$100.00
CMAC	\$110.00
Allowed amount	\$100.00
10% abatement (\$100 x 0.10)	\$10.00
Adjusted allowed amount (\$100 - \$10)	\$90.00
Provider billed charge to beneficiary (Limited to billed amount.)	\$100.00

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EXAMPLE 4: Non-Participating Provider Refuses To File Claim Or Has Charged An Administrative Fee

Billed charge	\$150.00
CMAC	\$100.00
Allowed amount	\$100.00
10% abatement (\$100 x 0.10)	\$10.00
Adjusted allowed amount (\$100 - \$10)	\$90.00
Provider billed charge to beneficiary (\$90.00 x 115%)	\$103.50

1. Provider bulletins shall be used to notify authorized providers of the balance billing limitation of the amount that may be billed by a non-participating provider to the beneficiary.

2. Contractors shall notify beneficiaries of the balance billing limitation and the amount that may be legally billed by a non-participating provider to the beneficiary through stuffers.

3. The following language shall be used to respond to beneficiary inquiries concerning the TRICARE non-participating provider balance billing provision. Routine stuffers shall not be used to convey this information.

NOTE: In accordance with 32 CFR 199, a balance billing limitation for services provided by non-participating providers was effective on and after November 1, 1993. This provision limits non-participating providers from billing TRICARE beneficiaries more than 115% of the TRICARE allowable charge which is shown on the Explanation Of Benefits (EOB). Please note when the provider's billed charge is less than 115% of the TRICARE allowed amount, the billed charge becomes the billable amount to the beneficiary. However, this restriction does not apply to noncovered services. Nonparticipating providers who do not comply with the limitation shall be subject to exclusion from the TRICARE program as authorized providers and may be excluded as a Medicare provider. If a non-participating provider bills and/or collects more from the beneficiary than the amount the provider may bill, contact the contractor's Program Integrity Department in writing. The beneficiary should include information which documents the higher billed amount, such as a copy of the EOB, bills from the non-participating provider to the beneficiary, demand letter from the non-participating provider to the beneficiary requesting an amount above the 115% of the allowable amount, and copies of cancelled checks that would identify excessive amounts paid by the beneficiary to the non-participating provider.

B. Failure To Comply

1. If a non-participating provider fails to comply with this balance billing limitation requirement, the provider shall be subject to exclusion from the TRICARE Program as an authorized provider and may be excluded as a Medicare provider.

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2. When the contractor receives a complaint that a non-participating provider is balance billing a beneficiary for an amount greater than 115% of the allowable charge, the contractor's Program Integrity Department shall investigate the complaint, communicate their findings to the beneficiary and take action against the provider, if appropriate. A beneficiary complaint letter will serve as a release form in order to educate the provider and as the basis for resolving the balance billing requirement. Only information where there is a need to know such as the billed charges should be discussed or released.

3. To exclude a provider from the TRICARE program, a pattern of such billing practices must be established along with documented evidence that the provider was advised of the balance billing limitation for non-participating providers, but continued to bill beneficiaries higher amounts after being notified.

4. Documented evidence could include certified registered mail, special provider news bulletins, and documented telephone conversations and/or meetings with the provider concerning his/her TRICARE billing practices as they related to the balance billing limitation. In addition, the contractor's Program Integrity Department shall follow the instructions in the TOM, [Chapter 14, Section 6](#).

C. Granting of Waiver Of Limitation

When requested by a TRICARE beneficiary, the contractor, on a case-by-case basis, may waive the balance billing limitation. If the beneficiary is willing to pay the non-participating provider for his/her billed charges, then the waiver shall be granted. The contractor shall obtain a signed statement from the beneficiary stating that he/she is aware that the provider is billing above the 115% limit, however, they feel strongly about using that provider and they are willing to pay the additional money. The beneficiary shall be advised that the provider still may be excluded from the TRICARE program, if he/she is over billing other TRICARE beneficiaries and they object. The waiver is controlled by the contractor, not by the provider. The contractor is responsible for communicating the potential costs to the beneficiary if the waiver statement is signed. A decision by the contractor to waive or not to waive the limit is not subject to the TRICARE appeals process.

- END -

SUBSTANCE USE DISORDER REHABILITATION FACILITIES REIMBURSEMENT

ISSUE DATE: June 26, 1995

AUTHORITY: 32 CFR 199.14(a)(1)(ii)(E) and (a)(2)(ix)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

Reimbursement of Substance Use Disorder Rehabilitation Facilities (SUDRF). This includes reimbursement for both inpatient and partial hospitalization for the treatment of substance use disorder rehabilitation care.

III. POLICY

A. Inpatient Substance Use Disorder Rehabilitation Facilities. Effective with admissions on or after July 1, 1995, authorized substance use disorder rehabilitation facilities are subject to the DRG-based payment system.

B. Partial hospitalization for the treatment of substance use disorders. Substance use disorder rehabilitation partial hospitalization services are reimbursed on the basis of prospectively determined all-inclusive per diem rates. The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, routine nursing services, ancillary services (includes art, music, dance, occupational and other such therapies), psychological testing and assessments, overhead and any other services for the customary practice among similar providers is included as part of the institutional charges.

C. Outpatient services will be reimbursed using the appropriate HCPCS code. Payment is not to exceed the allowable amount for CPT¹ procedure code 90853.

D. Family therapy provided on an inpatient or outpatient basis will be reimbursed under the CMAC for the procedure code(s) billed.

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CHAPTER 7, SECTION 3

SUBSTANCE USE DISORDER REHABILITATION FACILITIES REIMBURSEMENT

E. Cost-sharing. Effective for care on or after October 1, 1995, the cost-share for active duty dependents for inpatient substance use disorder services is \$20 per day for each day of the inpatient admission. The \$20.00 cost-share amount also applies to substance use disorder rehabilitation care provided in a partial hospitalization setting. The inpatient cost-share applies to the associated services billed separately by the individual professional providers. For care prior to October 1, 1995, the cost-share will be the daily rate or \$25.00, whichever is greater. For retirees and their dependents, the cost-share is 25 percent of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for active duty dependents is to be taken from the partial hospitalization facility claim.

- END -

AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT PRIOR TO IMPLEMENTATION OF OPPTS, AND THEREAFTER, FREESTANDING ASCs, AND NON-OPPS FACILITIES REIMBURSEMENT

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.14(d)

I. APPLICABILITY

The policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

II. ISSUE

Reimbursement of surgical procedures performed in an Ambulatory Surgical Center (ASC) prior to implementation of TRICARE's Outpatient Prospective Payment System (OPPS), and thereafter, freestanding ASCs, and other providers who are exempt from the TRICARE OPPTS and provide scheduled ambulatory surgery. For purposes of this section, these facilities are known as non-OPPS facilities. Non-OPPS facilities include any facility not subject to the OPPTS as outlined in Chapter 13, Section 1, paragraph III.D.1.b.

III. BACKGROUND

A. Reimbursement System Prior to Implementation of TRICARE's OPPTS.

1. General. Ambulatory surgery procedures performed in ASCs will be reimbursed using prospectively determined rates. The rates will be: established on a cost-basis, divided into eleven payment groups representing ranges of costs, and adjusted for area labor costs based on Metropolitan Statistical Areas (MSAs).

2. Applicability.

a. This payment system applies to all ambulatory surgery procedures identified in the list in Addendums A and B. (Creation and updating of Addendums A and B is the responsibility of TMA, and the inclusion or omission of any given procedure in Addendums A and B cannot be the basis for appealing any claim. Changes to Addendums A and B will be provided to the contractors when changes are made.) The payment system is to be used for ambulatory surgery procedures performed prior to implementation of OPPTS, regardless of

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AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT PRIOR TO IMPLEMENTATION OF OPPTS, AND THEREAFTER, FREESTANDING ASCs, AND NON-OPPTS FACILITIES

where the ambulatory surgery procedures are provided, that is, in a freestanding ASC, in a hospital outpatient department, or in a hospital emergency room (ER).

b. The payment system is to be used for ambulatory surgery procedures provided in freestanding ASCs. The payment rates established under this system apply only to the facility charges for ambulatory surgery. The facility rate is a standard overhead amount that includes nursing and technician services; use of the facility; drugs including take-home drugs for less than \$40; biologicals; surgical dressings, splints, casts and equipment directly related to provision of the surgical procedure; materials for anesthesia; intraocular lenses (IOLs); and administrative, recordkeeping and housekeeping items and services. The rate does not include items such as physicians' fees (or fees of other professional providers authorized to render the services identified in [Addendums A and B](#) and to bill independently for them); laboratory, X-rays or diagnostic procedures (other than those directly related to the performance of the surgical procedure); prosthetic devices (except IOLs); ambulance services; leg, arm, and back braces; artificial limbs; and durable medical equipment for use in the patient's home.

NOTE: A radiology and diagnostic procedure is considered directly related to the performance of the surgical procedure only if it is an inherent part of the surgical procedure, e.g., the CPT code for the surgical procedure includes the diagnostic or radiology procedure as part of the code description (i.e., CPT¹ procedure code 47560).

3. State Waiver. Ambulatory surgery services provided by freestanding ASCs in Maryland are not exempt from this system and are to be reimbursed using the procedures set forth in this section. (See [Chapter 1, Section 24, paragraph III.E.](#) for payment of professional services related to ambulatory surgery.)

4. Ambulatory Surgery Payment Rates.

a. TMA, or its data contractor, will calculate the payment rates and will provide them electronically to the claims processing contractors. The magnetic media will include the locally-adjusted payment rate for each payment group for each MSA and will identify, by procedure code, the procedures in each group and the effective date for each procedure. Additions or deletions to the list of procedures will be given to the contractors as they occur, but the electronic data will be provided only on an annual basis. The MSAs and corresponding wage indexes will be those used by Medicare.

b. In addition to the payment rates, the contractors will be provided a zip code to MSA crosswalk, so that they can determine which payment rate to use for each ambulatory surgery provider. For this purpose the zip code of the facility's physical address (as opposed to its billing address) is to be used. This crosswalk may be updated periodically throughout the year and sent to the contractors.

c. In order to calculate payment rates, only those procedures with at least 25 claims nationwide during the database period will be used.

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The following CPT codes, TRICARE payment groups, and short descriptions are valid for claims on or before October 31, 2003. See [Chapter 9, Addendum B](#) for claims occurring on or after November 1, 2003.

INTEGUMENTARY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
SKIN, SUBCUTANEOUS AND AREOLAR TISSUES		
CPT SUBSECTION: INCISION		
10121 ¹⁹	4	REMOVE FOREIGN BODY
10180	4	COMPLEX DRAINAGE, WOUND
CPT SUBSECTION: EXCISION DEBRIDEMENT		
11010 ¹⁹	4	DEBRIDE SKIN, FX
11011 ¹⁹	4	DEBRIDE SKIN/MUSCLE, FX
11012 ¹⁹	4	DEBRIDE SKIN/MUSCLE/BONE, FX
11042	1	DEBRIDE SKIN/TISSUE
11043	4	DEBRIDE TISSUE/MUSCLE
11044	4	DEBRIDE TISSUE/MUSCLE/BONE
CPT SUBSECTION: EXCISION-BENIGN LESIONS		
11404	3	REMOVAL OF SKIN LESION
11406	3	REMOVAL OF SKIN LESION
11424	4	REMOVAL OF SKIN LESION
11426	4	REMOVAL OF SKIN LESION
11444	2	REMOVAL OF SKIN LESION
11446	4	REMOVAL OF SKIN LESION
11450	4	REMOVAL, SWEAT GLAND LESION
11451	4	REMOVAL, SWEAT GLAND LESION
11462	4	REMOVAL, SWEAT GLAND LESION
11463	4	REMOVAL, SWEAT GLAND LESION
11470	4	REMOVAL, SWEAT GLAND LESION
11471	4	REMOVAL, SWEAT GLAND LESION
CPT SUBSECTION: EXCISION-MALIGNANT LESIONS		
11604	4	REMOVAL OF SKIN LESION
11606	4	REMOVAL OF SKIN LESION
11624	4	REMOVAL OF SKIN LESION
11626	4	REMOVAL OF SKIN LESION
11644	4	REMOVAL OF SKIN LESION
11646	4	REMOVAL OF SKIN LESION

* The number following the procedure code is the TRICARE payment group.

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INTEGUMENTARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: MISCELLANEOUS		
11770	5	REMOVAL OF PILONIDAL LESION
11771	6	REMOVAL OF PILONIDAL LESION
11772	5	REMOVAL OF PILONIDAL LESION
CPT SUBSECTION: INTRODUCTION		
11960	4	INSERT TISSUE EXPANDER(S)
11970	5	REPLACE TISSUE EXPANDER
11971	2	REMOVE TISSUE EXPANDER(S)
CPT SUBSECTION: REPAIR-SIMPLE		
12005	1	REPAIR SUPERFICIAL WOUND(S)
12006	4	REPAIR SUPERFICIAL WOUND(S)
12007	4	REPAIR SUPERFICIAL WOUND(S)
12016	4	REPAIR SUPERFICIAL WOUND(S)
12017	4	REPAIR SUPERFICIAL WOUND(S)
12018	4	REPAIR SUPERFICIAL WOUND(S)
12020	2	CLOSURE OF SPLIT WOUND
12021	2	CLOSURE OF SPLIT WOUND
CPT SUBSECTION: REPAIR-INTERMEDIATE		
12034	1	LAYER CLOSURE OF WOUND(S)
12035	4	LAYER CLOSURE OF WOUND(S)
12036	4	LAYER CLOSURE OF WOUND(S)
12037	4	LAYER CLOSURE OF WOUND(S)
12044	4	LAYER CLOSURE OF WOUND(S)
12045	4	LAYER CLOSURE OF WOUND(S)
12046	4	LAYER CLOSURE OF WOUND(S)
12047	4	LAYER CLOSURE OF WOUND(S)
12054	4	LAYER CLOSURE OF WOUND(S)
12055	4	LAYER CLOSURE OF WOUND(S)
12056	4	LAYER CLOSURE OF WOUND(S)
12057	4	LAYER CLOSURE OF WOUND(S)
CPT SUBSECTION: REPAIR-COMPLEX		
13100	4	REPAIR OF WOUND OR LESION
13101	5	REPAIR OF WOUND OR LESION
13102 ¹³	3	REPAIR WOUND/LESION ADD-ON
13120	4	REPAIR OF WOUND OR LESION
13121	1	REPAIR OF WOUND OR LESION
13122 ¹³	3	REPAIR WOUND/LESION ADD-ON
13131	1	REPAIR OF WOUND OR LESION
13132	2	REPAIR OF WOUND OR LESION
13133 ¹³	3	REPAIR WOUND/LESION ADD-ON
13150	5	REPAIR OF WOUND OR LESION
13151	1	REPAIR OF WOUND OR LESION
13152	2	REPAIR OF WOUND OR LESION
13153 ¹³	3	REPAIR WOUND/LESION ADD-ON
13160	4	LATE CLOSURE OF WOUND

* The number following the procedure code is the TRICARE payment group.

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INTEGUMENTARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
13300 ¹²	3	REPAIR OF WOUND OR LESION
CPT SUBSECTION: ADJACENT TISSUE TRANSFER OR REARRANGEMENT		
14000	4	SKIN TISSUE REARRANGEMENT
14001	5	SKIN TISSUE REARRANGEMENT
14020	5	SKIN TISSUE REARRANGEMENT
14021	5	SKIN TISSUE REARRANGEMENT
14040	3	SKIN TISSUE REARRANGEMENT
14041	5	SKIN TISSUE REARRANGEMENT
14060	5	SKIN TISSUE REARRANGEMENT
14061	5	SKIN TISSUE REARRANGEMENT
14300	6	SKIN TISSUE REARRANGEMENT
14350	5	SKIN TISSUE REARRANGEMENT
CPT SUBSECTION: FREE SKIN GRAFTS		
15000	4	SKIN GRAFT
15050	4	SKIN PINCH GRAFT
15100	4	SKIN SPLIT GRAFT
15101	5	SKIN SPLIT GRAFT ADD-ON
15120	4	SKIN SPLIT GRAFT
15121	5	SKIN SPLIT GRAFT ADD-ON
15200	5	SKIN FULL GRAFT
15201	4	SKIN FULL GRAFT ADD-ON
15220	4	SKIN FULL GRAFT
15221	4	SKIN FULL GRAFT ADD-ON
15240	5	SKIN FULL GRAFT
15241	5	SKIN FULL GRAFT ADD-ON
15260	5	SKIN FULL GRAFT
15261	4	SKIN FULL GRAFT ADD-ON
15350	4	SKIN HOMOGRAFT
15351 ¹⁹	4	SKIN HOMOGRAFT ADD-ON
15400	4	SKIN HETEROGRAFT
15401 ¹⁹	4	SKIN HETEROGRAFT ADD-ON
15570	5	FORM SKIN PEDICLE FLAP
15572	5	FORM SKIN PEDICLE FLAP
15574	5	FORM SKIN PEDICLE FLAP
15576	5	FORM SKIN PEDICLE FLAP
15580 ¹²	5	ATTACH SKIN PEDICLE GRAFT
15600	5	SKIN GRAFT
15610	5	SKIN GRAFT
15620	6	SKIN GRAFT
CPT SUBSECTION: PEDICLE FLAPS (SKIN AND DEEP TISSUES)		
15625 ¹²	5	SKIN GRAFT PROCEDURE
15630	5	SKIN GRAFT
15650	7	TRANSFER SKIN PEDICLE FLAP
CPT SUBSECTION: FLAPS (SKIN AND/OR DEEP TISSUES)		
15732	5	MUSCLE-SKIN GRAFT, HEAD/NECK

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INTEGUMENTARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
15734	5	MUSCLE-SKIN GRAFT, TRUNK
15736	5	MUSCLE-SKIN GRAFT, ARM
15738	5	MUSCLE-SKIN GRAFT, LEG
CPT SUBSECTION: OTHER GRAFTS		
15740	4	ISLAND PEDICLE FLAP GRAFT
15750	4	NEUROVASCULAR PEDICLE GRAFT
15755 ¹⁰	5	FLAP; FREE FLAP (MICROVASCULAR TRANSFER)
15756 ^{9, 20}	5	FREE MUSCLE FLAP, MICROVASC
15757 ^{9, 20}	5	FREE SKIN FLAP, MICROVASC
15758 ^{9, 20}	5	FREE FASCIAL FLAP, MICROVASC
15760	4	COMPOSITE SKIN GRAFT
15770	5	DERMA-FAT-FASCIA GRAFT
15775 ¹⁹	5	HAIR TRANSPLANT PUNCH GRAFTS
15776 ¹⁹	5	HAIR TRANSPLANT PUNCH GRAFTS
CPT SUBSECTION: MISCELLANEOUS PROCEDURES		
15820 ¹⁹	5	REVISION OF LOWER EYELID
15821 ¹⁹	5	REVISION OF LOWER EYELID
15822 ¹⁹	5	REVISION OF UPPER EYELID
15823 ¹⁹	7	REVISION OF UPPER EYELID
15824 ¹⁹	5	REMOVAL OF FOREHEAD WRINKLES
15825 ¹⁹	5	REMOVAL OF NECK WRINKLES
15826 ¹⁹	5	REMOVAL OF BROW WRINKLES
15827 ¹⁹	5	REMOVAL OF FACE WRINKLES
15828 ¹⁹	7	REMOVAL OF SKIN WRINKLES
15831 ¹⁹	5	EXCISE EXCESSIVE SKIN TISSUE
15832 ¹⁹	5	EXCISE EXCESSIVE SKIN TISSUE
15833 ¹⁹	5	EXCISE EXCESSIVE SKIN TISSUE
15834 ¹⁹	5	EXCISE EXCESSIVE SKIN TISSUE
15835 ¹⁹	5	EXCISE EXCESSIVE SKIN TISSUE
15840	6	GRAFT FOR FACE NERVE PALSY
15841	6	GRAFT FOR FACE NERVE PALSY
15842 ²⁰	6	FLAP FOR FACE NERVE PALSY
15845	6	SKIN AND MUSCLE REPAIR, FACE
15876 ¹⁹	5	SUCTION ASSISTED LIPECTOMY
15877 ¹⁹	5	SUCTION ASSISTED LIPECTOMY
15878 ¹⁹	5	SUCTION ASSISTED LIPECTOMY
15879 ¹⁹	5	SUCTION ASSISTED LIPECTOMY
CPT SUBSECTION: PRESSURE ULCERS (DECUBITUS ULCERS)		
15920	5	REMOVAL OF TAIL BONE ULCER
15922	6	REMOVAL OF TAIL BONE ULCER
15931	5	REMOVE SACRUM PRESSURE SORE
15933	5	REMOVE SACRUM PRESSURE SORE
15934	5	REMOVE SACRUM PRESSURE SORE
15935	6	REMOVE SACRUM PRESSURE SORE
15936	6	REMOVE SACRUM PRESSURE SORE

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INTEGUMENTARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
15937	6	REMOVE SACRUM PRESSURE SORE
15940	5	REMOVE HIP PRESSURE SORE
15941	5	REMOVE HIP PRESSURE SORE
15944	5	REMOVE HIP PRESSURE SORE
15945	6	REMOVE HIP PRESSURE SORE
15946	6	REMOVE HIP PRESSURE SORE
15950	5	REMOVE THIGH PRESSURE SORE
15951	6	REMOVE THIGH PRESSURE SORE
15952	5	REMOVE THIGH PRESSURE SORE
15953	6	REMOVE THIGH PRESSURE SORE
15956	5	REMOVE THIGH PRESSURE SORE
15958	6	REMOVE THIGH PRESSURE SORE
CPT SUBSECTION: BURNS, LOCAL TREATMENT		
16015	4	TREATMENT OF BURN(S)
16030 ²⁰	2	TREATMENT OF BURN(S)
16035 ²⁰	4	INCISION OF BURN SCAB, INITI
CPT SUBSECTION: DESTRUCTION, BENIGN OR PREMALIGNANT LESIONS		
17106 ⁶	1	DESTRUCTION OF SKIN LESIONS
17107 ⁶	1	DESTRUCTION OF SKIN LESIONS
17108 ⁶	3	DESTRUCTION OF SKIN LESIONS
BREAST		
CPT SUBSECTION: INCISION		
19020	4	INCISION OF BREAST LESION
CPT SUBSECTION: EXCISION		
19100	3	BX BREAST PERCUT W/O IMAGE
19101	6	BIOPSY OF BREAST, OPEN
19102 ¹⁵	4	BX BREAST PERCUT W/IMAGE
19103 ¹⁵	4	BX BREAST PERCUT W/DEVICE
19110	4	NIPPLE EXPLORATION
19112	5	EXCISE BREAST DUCT FISTULA
19120	6	REMOVAL OF BREAST LESION
19125	5	EXCISION, BREAST LESION
19126	5	EXCISION, ADDL BREAST LESION
19140	6	REMOVAL OF BREAST TISSUE
19160	8	REMOVAL OF BREAST TISSUE
19162	9	REMOVE BREAST TISSUE, NODES
19180	6	REMOVAL OF BREAST
19182	6	REMOVAL OF BREAST
19260 ²⁰	7	REMOVAL OF CHEST WALL LESION
CPT SUBSECTION: INTRODUCTION		
19290 ⁸	3	PLACE NEEDLE WIRE, BREAST
19291 ⁸	3	PLACE NEEDLE WIRE, BREAST
CPT SUBSECTION: REPAIR AND RECONSTRUCTION		
19316 ¹⁹	6	SUSPENSION OF BREAST

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INTEGUMENTARY SYSTEM (CONTINUED)

CPT CODE	TRICARE	
	PAYMENT GROUP*	SHORT DESCRIPTION**
19318	6	REDUCTION OF LARGE BREAST
19324 ¹⁹	6	ENLARGE BREAST
19325 ¹⁹	10	ENLARGE BREAST WITH IMPLANT
19328	2	REMOVAL OF BREAST IMPLANT
19330	2	REMOVAL OF IMPLANT MATERIAL
19340	4	IMMEDIATE BREAST PROSTHESIS
19342	5	DELAYED BREAST PROSTHESIS
19350	6	BREAST RECONSTRUCTION
19355 ¹⁹	6	CORRECT INVERTED NIPPLE(S)
19357	7	BREAST RECONSTRUCTION
19364 ²⁰	7	BREAST RECONSTRUCTION
19366	7	BREAST RECONSTRUCTION
19370	6	SURGERY OF BREAST CAPSULE
19371	6	REMOVAL OF BREAST CAPSULE
19380	7	REVISE BREAST RECONSTRUCTION

MUSCULOSKELETAL SYSTEM

CPT CODE	TRICARE	
	PAYMENT GROUP*	SHORT DESCRIPTION**
GENERAL		
CPT SUBSECTION: INCISION		
20005	4	INCISION OF DEEP ABSCESS
CPT SUBSECTION: EXCISION		
20200	4	MUSCLE BIOPSY
20205	5	DEEP MUSCLE BIOPSY
20206	2	NEEDLE BIOPSY, MUSCLE
20220	2	BONE BIOPSY, TROCAR/NEEDLE
20225	4	BONE BIOPSY, TROCAR/NEEDLE
20240	4	BONE BIOPSY, EXCISIONAL
20245	5	BONE BIOPSY, EXCISIONAL
20250	5	OPEN BONE BIOPSY
20251	5	OPEN BONE BIOPSY
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
20525	5	REMOVAL OF FOREIGN BODY
20650	5	INSERT AND REMOVE BONE PIN
20660 ²⁰	4	APPLY, REMOVE FIXATION DEVICE
20661 ²⁰	5	APPLICATION OF HEAD BRACE
20662 ²⁰	5	APPLICATION OF PELVIS BRACE
20663 ²⁰	5	APPLICATION OF THIGH BRACE
20665 ²⁰	2	REMOVAL OF FIXATION DEVICE
20670	4	REMOVAL OF SUPPORT IMPLANT
20680	6	REMOVAL OF SUPPORT IMPLANT
20690	4	APPLY BONE FIXATION DEVICE
20692 ¹⁹	5	APPLY BONE FIXATION DEVICE
20693 ¹⁹	5	ADJUST BONE FIXATION DEVICE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
20694 ²	2	REMOVE BONE FIXATION DEVICE
CPT SUBSECTION: GRAFTS (OR IMPLANTS)		
20900	5	REMOVAL OF BONE FOR GRAFT
20902	6	REMOVAL OF BONE FOR GRAFT
20910 ²	5	REMOVE CARTILAGE FOR GRAFT
20912	5	REMOVE CARTILAGE FOR GRAFT
20920	6	REMOVAL OF FASCIA FOR GRAFT
20922	5	REMOVAL OF FASCIA FOR GRAFT
20924	6	REMOVAL OF TENDON FOR GRAFT
20926	6	REMOVAL OF TISSUE FOR GRAFT
CPT SUBSECTION: MISCELLANEOUS		
20955 ²⁰	6	FIBULA BONE GRAFT, MICROVASC
20960 ¹⁰	6	BONE GRAFT WITH MICROVASCULAR ANASTOMOSIS; RIB
20962 ²⁰	6	OTHER BONE GRAFT, MICROVASC
20969 ²⁰	6	BONE/SKIN GRAFT, MICROVASC
20970 ²⁰	6	BONE/SKIN GRAFT, ILIAC CREST
20971 ¹⁰	6	FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR ANASTOMOSIS; RIB
20972 ²⁰	6	BONE/SKIN GRAFT, METATARSAL
20973 ²⁰	6	BONE/SKIN GRAFT, GREAT TOE
20975	4	ELECTRICAL BONE STIMULATION
HEAD		
CPT SUBSECTION: INCISION		
21010	4	INCISION OF JAW JOINT
CPT SUBSECTION: EXCISION		
21015 ¹⁹	5	RESECTION OF FACIAL TUMOR
21025	4	EXCISION OF BONE, LOWER JAW
21026	4	EXCISION OF FACIAL BONE(S)
21029 ¹⁹	4	CONTOUR OF FACE BONE LESION
21034	5	REMOVAL OF FACE BONE LESION
21040	4	REMOVAL OF JAW BONE LESION
21041 ²⁰	4	REMOVAL OF JAW BONE LESION
21044	4	REMOVAL OF JAW BONE LESION
21046 ¹⁹	4	EXCISION, BENIGN TUMOR, MANDIBLE
21047 ¹⁹	4	EXCISION, BENIGN TUMOR, MANDIBLE
21050	5	REMOVAL OF JAW JOINT
21060	4	REMOVE JAW JOINT CARTILAGE
21070	5	REMOVE CORONOID PROCESS
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
21100	4	MAXILLOFACIAL FIXATION
CPT SUBSECTION: REPAIR, REVISION, OR RECONSTRUCTION		
21121 ¹⁹	9	RECONSTRUCTION OF CHIN
21122 ¹⁹	9	RECONSTRUCTION OF CHIN
21123 ¹⁹	9	RECONSTRUCTION OF CHIN

* The number following the procedure code is the TRICARE payment group.

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
21127 ¹⁹	10	AUGMENTATION, LOWER JAW BONE
21181 ¹⁹	9	CONTOUR CRANIAL BONE LESION
21206	7	RECONSTRUCT UPPER JAW BONE
21208	9	AUGMENTATION OF FACIAL BONES
21209	7	REDUCTION OF FACIAL BONES
21210	9	FACE BONE GRAFT
21215	9	LOWER JAW BONE GRAFT
21230	9	RIB CARTILAGE GRAFT
21235	9	EAR CARTILAGE GRAFT
21240	6	RECONSTRUCTION OF JAW JOINT
21242	7	RECONSTRUCTION OF JAW JOINT
21243	7	RECONSTRUCTION OF JAW JOINT
21244	9	RECONSTRUCTION OF LOWER JAW
21245	9	RECONSTRUCTION OF JAW
21246	9	RECONSTRUCTION OF JAW
21248	9	RECONSTRUCTION OF JAW
21249	9	RECONSTRUCTION OF JAW
21267	9	REVISE EYE SOCKETS
21270	7	AUGMENTATION, CHEEK BONE
21275	9	REVISION, ORBITOFACIAL BONES
21280	7	REVISION OF EYELID
21282	7	REVISION OF EYELID
21295 ¹⁹	2	RECONST LWR JAW W/O FIXATION
21296 ¹⁹	2	RECONST LWR JAW W/ FIXATION
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
21300	4	TREATMENT OF SKULL FRACTURE
21310	4	TREATMENT OF NOSE FRACTURE
21315	4	TREATMENT OF NOSE FRACTURE
21320	5	TREATMENT OF NOSE FRACTURE
21325	6	TREATMENT OF NOSE FRACTURE
21330	7	TREATMENT OF NOSE FRACTURE
21335	8	TREATMENT OF NOSE FRACTURE
21336 ¹⁹	6	TREAT NASAL SEPTAL FRACTURE
21337	4	TREAT NASAL SEPTAL FRACTURE
21338	6	TREAT NASOETHMOID FRACTURE
21339	7	TREAT NASOETHMOID FRACTURE
21340	6	TREATMENT OF NOSE FRACTURE
21343 ²⁰	7	TREATMENT OF SINUS FRACTURE
21345 ¹⁹	9	TREAT NOSE/JAW FRACTURE
21355	5	TREAT CHEEK BONE FRACTURE
21360 ²⁰	6	TREAT CHEEK BONE FRACTURE
21365 ²⁰	7	TREAT CHEEK BONE FRACTURE
21385 ²⁰	7	TREAT EYE SOCKET FRACTURE
21386 ²⁰	7	TREAT EYE SOCKET FRACTURE
21387 ²⁰	7	TREAT EYE SOCKET FRACTURE
21390 ²⁰	9	TREAT EYE SOCKET FRACTURE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
21395 ²⁰	9	TREAT EYE SOCKET FRACTURE
21400	4	TREAT EYE SOCKET FRACTURE
21401	5	TREAT EYE SOCKET FRACTURE
21406 ²⁰	6	TREAT EYE SOCKET FRACTURE
21407 ²⁰	7	TREAT EYE SOCKET FRACTURE
21421	6	TREAT MOUTH ROOF FRACTURE
21422 ²⁰	7	TREAT MOUTH ROOF FRACTURE
21440	5	TREAT DENTAL RIDGE FRACTURE
21445	6	TREAT DENTAL RIDGE FRACTURE
21450	5	TREAT LOWER JAW FRACTURE
21451	6	TREAT LOWER JAW FRACTURE
21452	4	TREAT LOWER JAW FRACTURE
21453	5	TREAT LOWER JAW FRACTURE
21454	7	TREAT LOWER JAW FRACTURE
21461	6	TREAT LOWER JAW FRACTURE
21462	7	TREAT LOWER JAW FRACTURE
21465	6	TREAT LOWER JAW FRACTURE
21470 ²⁰	7	TREAT LOWER JAW FRACTURE
21480	2	RESET DISLOCATED JAW
21485	4	RESET DISLOCATED JAW
21490	5	REPAIR DISLOCATED JAW
21493	5	TREAT HYOID BONE FRACTURE
21494	6	TREAT HYOID BONE FRACTURE
21495 ²⁰	6	TREAT HYOID BONE FRACTURE
21497	4	INTERDENTAL WIRING
NECK (SOFT TISSUES) AND THORAX		
CPT SUBSECTION: INCISION		
21501	4	DRAIN NECK/CHEST LESION
21502	4	DRAIN CHEST LESION
21510 ²⁰	5	DRAINAGE OF BONE LESION
CPT SUBSECTION: EXCISION		
21550 ²⁰	2	BIOPSY OF NECK/CHEST
21555	4	REMOVE LESION, NECK/CHEST
21556	4	REMOVE LESION, NECK/CHEST
21600	4	PARTIAL REMOVAL OF RIB
21610	4	PARTIAL REMOVAL OF RIB
21620 ²⁰	4	PARTIAL REMOVAL OF STERNUM
CPT SUBSECTION: REPAIR, REVISION OR RECONSTRUCTION		
21700	4	REVISION OF NECK MUSCLE
21720	5	REVISION OF NECK MUSCLE
21725	5	REVISION OF NECK MUSCLE
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
21800	2	TREATMENT OF RIB FRACTURE
21805	4	TREATMENT OF RIB FRACTURE
21810 ²⁰	4	TREATMENT OF RIB FRACTURE(S)

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
21820	2	TREAT STERNUM FRACTURE
BACK AND FLANK		
CPT SUBSECTION: EXCISION		
21920 ²⁰	2	BIOPSY SOFT TISSUE OF BACK
21925	4	BIOPSY SOFT TISSUE OF BACK
21930	4	REMOVE LESION, BACK OR FLANK
21935	5	REMOVE TUMOR, BACK
SPINE (VERTEBRAL COLUMN)		
CPT SUBSECTION: EXCISION		
22100 ²⁰	5	REMOVE PART OF NECK VERTEBRA
22101 ²⁰	5	REMOVE PART, THORAX VERTEBRA
22102 ²⁰	5	REMOVE PART, LUMBAR VERTEBRA
22103 ^{8, 20}	5	REMOVE EXTRA SPINE SEGMENT
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
22305	2	TREAT SPINE PROCESS FRACTURE
22310	2	TREAT SPINE FRACTURE
22315	4	TREAT SPINE FRACTURE
22325 ²⁰	5	TREAT SPINE FRACTURE
22326 ²⁰	5	TREAT NECK SPINE FRACTURE
22327 ²⁰	5	TREAT THORAX SPINE FRACTURE
22328 ^{8, 20}	5	TREAT EACH ADD SPINE FX
CPT SUBSECTION: MANIPULATION		
22505	4	MANIPULATION OF SPINE
ABDOMEN		
CPT SUBSECTION: EXCISION		
22900	6	REMOVE ABDOMINAL WALL LESION
SHOULDER		
CPT SUBSECTION: INCISION		
23000	4	REMOVAL OF CALCIUM DEPOSITS
23020	4	RELEASE SHOULDER JOINT
23030	2	DRAIN SHOULDER LESION
23031 ¹⁹	5	DRAIN SHOULDER BURSA
23035	5	DRAIN SHOULDER BONE LESION
23040	5	EXPLORATORY SHOULDER SURGERY
23044	6	EXPLORATORY SHOULDER SURGERY
CPT SUBSECTION: EXCISION		
23065 ²⁰	2	BIOPSY SHOULDER TISSUES
23066	4	BIOPSY SHOULDER TISSUES
23075	4	REMOVAL OF SHOULDER LESION
23076	4	REMOVAL OF SHOULDER LESION
23077	5	REMOVE TUMOR OF SHOULDER
23100	4	BIOPSY OF SHOULDER JOINT
23101	9	SHOULDER JOINT SURGERY
23105	6	REMOVE SHOULDER JOINT LINING

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
23106	6	INCISION OF COLLARBONE JOINT
23107	6	EXPLORE TREAT SHOULDER JOINT
23120	7	PARTIAL REMOVAL, COLLAR BONE
23125	7	REMOVAL OF COLLAR BONE
23130	7	REMOVE SHOULDER BONE, PART
23140	6	REMOVAL OF BONE LESION
23145	7	REMOVAL OF BONE LESION
23146	7	REMOVAL OF BONE LESION
23150	6	REMOVAL OF HUMERUS LESION
23155	7	REMOVAL OF HUMERUS LESION
23156	7	REMOVAL OF HUMERUS LESION
23170	4	REMOVE COLLAR BONE LESION
23172	4	REMOVE SHOULDER BLADE LESION
23174	4	REMOVE HUMERUS LESION
23180	6	REMOVE COLLAR BONE LESION
23182	6	REMOVE SHOULDER BLADE LESION
23184	6	REMOVE HUMERUS LESION
23190	6	PARTIAL REMOVAL OF SCAPULA
23195	7	REMOVAL OF HEAD OF HUMERUS
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
23330	2	REMOVE SHOULDER FOREIGN BODY
23331	2	REMOVE SHOULDER FOREIGN BODY
CPT SUBSECTION: REPAIR, REVISION OR RECONSTRUCTION		
23395	7	MUSCLE TRANSFER, SHOULDER/ ARM
23397	9	MUSCLE TRANSFERS
23400	9	FIXATION OF SHOULDER BLADE
23405	4	INCISION OF TENDON & MUSCLE
23406	4	INCISE TENDON(S) & MUSCLE(S)
23410	7	REPAIR OF TENDON(S)
23412	9	REPAIR OF TENDON(S)
23415	7	RELEASE OF SHOULDER LIGAMENT
23420	9	REPAIR OF SHOULDER
23430	6	REPAIR BICEPS TENDON
23440	6	REMOVE/TRANSPLANT TENDON
23450	7	REPAIR SHOULDER CAPSULE
23455	9	REPAIR SHOULDER CAPSULE
23460	7	REPAIR SHOULDER CAPSULE
23462	9	REPAIR SHOULDER CAPSULE
23465	7	REPAIR SHOULDER CAPSULE
23466	9	REPAIR SHOULDER CAPSULE
23480	6	REVISION OF COLLAR BONE
23485	9	REVISION OF COLLAR BONE
23490	5	REINFORCE CLAVICLE
23491	5	REINFORCE SHOULDER BONES
23500	1	TREAT CLAVICLE FRACTURE
23505	2	TREAT CLAVICLE FRACTURE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
23515	5	TREAT CLAVICLE FRACTURE
23520	2	TREAT CLAVICLE DISLOCATION
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
23525	2	TREAT CLAVICLE DISLOCATION
23530	5	TREAT CLAVICLE DISLOCATION
23532	6	TREAT CLAVICLE DISLOCATION
23540	2	TREAT CLAVICLE DISLOCATION
23545	2	TREAT CLAVICLE DISLOCATION
23550	5	TREAT CLAVICLE DISLOCATION
23552	6	TREAT CLAVICLE DISLOCATION
23570	2	TREAT SHOULDER BLADE FX
23575	2	TREAT SHOULDER BLADE FX
23585	5	TREAT SCAPULA FRACTURE
23600	2	TREAT HUMERUS FRACTURE
23605	4	TREAT HUMERUS FRACTURE
23615	6	TREAT HUMERUS FRACTURE
23616	6	TREAT HUMERUS FRACTURE
23620	2	TREAT HUMERUS FRACTURE
23625	4	TREAT HUMERUS FRACTURE
23630	7	TREAT HUMERUS FRACTURE
23650	1	TREAT SHOULDER DISLOCATION
23655	1	TREAT SHOULDER DISLOCATION
23660	5	TREAT SHOULDER DISLOCATION
23665	4	TREAT DISLOCATION/FRACTURE
23670	5	TREAT DISLOCATION/FRACTURE
23675	4	TREAT DISLOCATION/FRACTURE
23680	5	TREAT DISLOCATION/FRACTURE
CPT SUBSECTION: MANIPULATION		
23700	1	FIXATION OF SHOULDER
CPT SUBSECTION: ARTHRODESIS		
23800	6	FUSION OF SHOULDER JOINT
23802	9	FUSION OF SHOULDER JOINT
CPT SUBSECTION: AMPUTATION		
23921	5	AMPUTATION FOLLOW-UP SURGERY
HUMERUS (UPPER ARM) AND ELBOW		
CPT SUBSECTION: INCISION		
23930	2	DRAINAGE OF ARM LESION
23931	4	DRAINAGE OF ARM BURSA
23935	4	DRAIN ARM/ELBOW BONE LESION
CPT SUBSECTION: EXCISION		
24000	6	EXPLORATORY ELBOW SURGERY
24006 ¹⁹	6	RELEASE ELBOW JOINT
24065 ²⁰	2	BIOPSY ARM/ELBOW SOFT TISSUE
24066	4	BIOPSY ARM/ELBOW SOFT TISSUE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
24075	4	REMOVE ARM/ELBOW LESION
24076	4	REMOVE ARM/ELBOW LESION
24077	5	REMOVE TUMOR OF ARM/ELBOW
24100	2	BIOPSY ELBOW JOINT LINING
24101	6	EXPLORE/TREAT ELBOW JOINT
24102	6	REMOVE ELBOW JOINT LINING
24105	5	REMOVAL OF ELBOW BURSA
24110	4	REMOVE HUMERUS LESION
24115	5	REMOVE/GRAFT BONE LESION
24116	5	REMOVE/GRAFT BONE LESION
24120	5	REMOVE ELBOW LESION
24125	5	REMOVE/GRAFT BONE LESION
24126	5	REMOVE/GRAFT BONE LESION
24130	5	REMOVAL OF HEAD OF RADIUS
24134	4	REMOVAL OF ARM BONE LESION
24136	4	REMOVE RADIUS BONE LESION
24138	4	REMOVE ELBOW BONE LESION
24140	5	PARTIAL REMOVAL OF ARM BONE
24145	5	PARTIAL REMOVAL OF RADIUS
24147	4	PARTIAL REMOVAL OF ELBOW
24150 ²⁰	5	EXTENSIVE HUMERUS SURGERY
24151 ²⁰	6	EXTENSIVE HUMERUS SURGERY
24152 ²⁰	5	EXTENSIVE RADIUS SURGERY
24153 ²⁰	6	EXTENSIVE RADIUS SURGERY
24155	5	REMOVAL OF ELBOW JOINT
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
24160	4	REMOVE ELBOW JOINT IMPLANT
24164	5	REMOVE RADIUS HEAD IMPLANT
24201	4	REMOVAL OF ARM FOREIGN BODY
CPT SUBSECTION: REPAIR, REVISION AND RECONSTRUCTION		
24301	6	MUSCLE/TENDON TRANSFER
24305 ¹⁹	6	ARM TENDON LENGTHENING
24310	5	REVISION OF ARM TENDON
24320	5	REPAIR OF ARM TENDON
24330	5	REVISION OF ARM MUSCLES
24331	5	REVISION OF ARM MUSCLES
24340	5	REPAIR OF BICEPS TENDON
24341 ¹⁹	5	REPAIR ARM TENDON/MUSCLE
24342	5	REPAIR OF RUPTURED TENDON
24345 ¹⁹	4	REPR ELBW MED LIGMNT W/ TISSU
24350	5	REPAIR OF TENNIS ELBOW
24351	5	REPAIR OF TENNIS ELBOW
24352	5	REPAIR OF TENNIS ELBOW
24354	5	REPAIR OF TENNIS ELBOW
24356	5	REVISION OF TENNIS ELBOW
24360	7	RECONSTRUCT ELBOW JOINT

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
24361	7	RECONSTRUCT ELBOW JOINT
24362	7	RECONSTRUCT ELBOW JOINT
24363	9	REPLACE ELBOW JOINT
24365	7	RECONSTRUCT HEAD OF RADIUS
24366	7	RECONSTRUCT HEAD OF RADIUS
24400	6	REVISION OF HUMERUS
24410	6	REVISION OF HUMERUS
24420	5	REVISION OF HUMERUS
24430	5	REPAIR OF HUMERUS
24435	6	REPAIR HUMERUS WITH GRAFT
24470	5	REVISION OF ELBOW JOINT
24495	4	DECOMPRESSION OF FOREARM
24498	5	REINFORCE HUMERUS
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
24500	2	TREAT HUMERUS FRACTURE
24505	2	TREAT HUMERUS FRACTURE
24515	6	TREAT HUMERUS FRACTURE
24516	6	TREAT HUMERUS FRACTURE
24530	1	TREAT HUMERUS FRACTURE
24535	2	TREAT HUMERUS FRACTURE
24538	4	TREAT HUMERUS FRACTURE
24545	6	TREAT HUMERUS FRACTURE
24546	7	TREAT HUMERUS FRACTURE
24560	2	TREAT HUMERUS FRACTURE
24565	4	TREAT HUMERUS FRACTURE
24566	4	TREAT HUMERUS FRACTURE
24575	5	TREAT HUMERUS FRACTURE
24576	2	TREAT HUMERUS FRACTURE
24577	2	TREAT HUMERUS FRACTURE
24579	5	TREAT HUMERUS FRACTURE
24582	4	TREAT HUMERUS FRACTURE
24586	6	TREAT ELBOW FRACTURE
24587	7	TREAT ELBOW FRACTURE
24600	1	TREAT ELBOW DISLOCATION
24605	4	TREAT ELBOW DISLOCATION
24615	5	TREAT ELBOW DISLOCATION
24620	4	TREAT ELBOW FRACTURE
24635	5	TREAT ELBOW FRACTURE
24655	2	TREAT RADIUS FRACTURE
24665	6	TREAT RADIUS FRACTURE
24666	6	TREAT RADIUS FRACTURE
24670	2	TREAT ULNAR FRACTURE
24675	2	TREAT ULNAR FRACTURE
24685	5	TREAT ULNAR FRACTURE
CPT SUBSECTION: ARTHRODESIS		
24800	6	FUSION OF ELBOW JOINT

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
24802	7	FUSION/GRAFT OF ELBOW JOINT
CPT SUBSECTION: AMPUTATION		
24925	5	AMPUTATION FOLLOW-UP SURGERY
FOREARM AND WRIST		
CPT SUBSECTION: INCISION		
25000	5	INCISION OF TENDON SHEATH
25005 ³	5	TENDON SHEATH INCISION; AT WRIST FOR OTHER STENOSING TENOSYNOVITIS
25020	5	DECOMPRESS FOREARM 1 SPACE
25023	5	DECOMPRESS FOREARM 1 SPACE
25024 ¹⁶	5	DECOMPRESS FOREARM 2 SPACES
25025 ¹⁶	5	DECOMPRESS FOREARM 2 SPACES
25028	2	DRAINAGE OF FOREARM LESION
25031	4	DRAINAGE OF FOREARM BURSA
25035	4	TREAT FOREARM BONE LESION
25040	7	EXPLORE/TREAT WRIST JOINT
CPT SUBSECTION: EXCISION		
25065 ²⁰	2	BIOPSY FOREARM SOFT TISSUES
25066	4	BIOPSY FOREARM SOFT TISSUES
25075	4	REMOVE FOREARM LESION SUBCUT
25076	5	REMOVE FOREARM LESION DEEP
25077	5	REMOVE TUMOR, FOREARM/WRIST
25085	5	INCISION OF WRIST CAPSULE
25100	4	BIOPSY OF WRIST JOINT
25101	5	EXPLORE/TREAT WRIST JOINT
25105	6	REMOVE WRIST JOINT LINING
25107	5	REMOVE WRIST JOINT CARTILAGE
25110	5	REMOVE WRIST TENDON LESION
25111	6	REMOVE WRIST TENDON LESION
25112	6	REREMOVE WRIST TENDON LESION
25115	6	REMOVE WRIST/FOREARM LESION
25116	6	REMOVE WRIST/FOREARM LESION
25118	4	EXCISE WRIST TENDON SHEATH
25119	5	PARTIAL REMOVAL OF ULNA
25120	5	REMOVAL OF FOREARM LESION
25125	5	REMOVE/GRAFT FOREARM LESION
25126	5	REMOVE/GRAFT FOREARM LESION
25130	5	REMOVAL OF WRIST LESION
25135	5	REMOVE & GRAFT WRIST LESION
25136	5	REMOVE & GRAFT WRIST LESION
25145	4	REMOVE FOREARM BONE LESION
25150	4	PARTIAL REMOVAL OF ULNA
25151	4	PARTIAL REMOVAL OF RADIUS
25170 ²⁰	5	EXTENSIVE FOREARM SURGERY
25210	5	REMOVAL OF WRIST BONE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
25215	6	REMOVAL OF WRIST BONES
25230	6	PARTIAL REMOVAL OF RADIUS
25240	6	PARTIAL REMOVAL OF ULNA
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
25248	4	REMOVE FOREARM FOREIGN BODY
25250	2	REMOVAL OF WRIST PROSTHESIS
25251	2	REMOVAL OF WRIST PROSTHESIS
CPT SUBSECTION: REPAIR, REVISION AND RECONSTRUCTION		
25260	6	REPAIR FOREARM TENDON/MUSCLE
25263	4	REPAIR FOREARM TENDON/MUSCLE
25265	5	REPAIR FOREARM TENDON/MUSCLE
25270	6	REPAIR FOREARM TENDON/MUSCLE
25272	5	REPAIR FOREARM TENDON/MUSCLE
25274	6	REPAIR FOREARM TENDON/MUSCLE
25275 ¹⁶	6	REPAIR FOREARM TENDON SHEATH
25280	6	REVISE WRIST/FOREARM TENDON
25290	5	INCISE WRIST/FOREARM TENDON
25295	5	RELEASE WRIST/FOREARM TENDON
25300	5	FUSION OF TENDONS AT WRIST
25301	5	FUSION OF TENDONS AT WRIST
25310	5	TRANSPLANT FOREARM TENDON
25312	6	TRANSPLANT FOREARM TENDON
25315	5	REVISE PALSY HAND TENDON(S)
25316	5	REVISE PALSY HAND TENDON(S)
25317 ³	5	FLEXOR ORIGIN SLIDE FOR VOLKMANN CONTRACTURE
25318 ³	5	FLEXOR ORIGIN SLIDE FOR VOLKMANN CONTRACTURE; WITH TENDON(S) TRANSFER
25320	5	REPAIR/REVISE WRIST JOINT
25330 ¹⁰	7	ARTHROPLASTY, WRIST
25331 ¹⁰	7	ARTHROPLASTY, WRIST; WITH IMPLANT
25332	7	REVISE WRIST JOINT
25335	5	REALIGNMENT OF HAND
25337 ¹⁹	7	RECONSTRUCT ULNA/RADIOULNAR
25350	5	REVISION OF RADIUS
25355	5	REVISION OF RADIUS
25360	5	REVISION OF ULNA
25365	5	REVISE RADIUS & ULNA
25370	5	REVISE RADIUS OR ULNA
25375	6	REVISE RADIUS & ULNA
25390	5	SHORTEN RADIUS OR ULNA
25391	6	LENGTHEN RADIUS OR ULNA
25392	5	SHORTEN RADIUS & ULNA
25393	6	LENGTHEN RADIUS & ULNA
25400	5	REPAIR RADIUS OR ULNA
25405	6	REPAIR/GRAFT RADIUS OR ULNA
25415	5	REPAIR RADIUS & ULNA

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
25420	6	REPAIR/GRAFT RADIUS & ULNA
25425	5	REPAIR/GRAFT RADIUS OR ULNA
25426	6	REPAIR/GRAFT RADIUS & ULNA
25440	6	REPAIR/GRAFT WRIST BONE
25441	7	RECONSTRUCT WRIST JOINT
25442	7	RECONSTRUCT WRIST JOINT
25443	7	RECONSTRUCT WRIST JOINT
25444	7	RECONSTRUCT WRIST JOINT
25445	7	RECONSTRUCT WRIST JOINT
25446	9	WRIST REPLACEMENT
25447	7	REPAIR WRIST JOINT(S)
25449	7	REMOVE WRIST JOINT IMPLANT
25450	5	REVISION OF WRIST JOINT
25455	5	REVISION OF WRIST JOINT
25490	5	REINFORCE RADIUS
25491	5	REINFORCE ULNA
25492	5	REINFORCE RADIUS AND ULNA

CPT SUBSECTION: FRACTURE AND/OR DISLOCATION

25505	1	TREAT FRACTURE OF RADIUS
25515	5	TREAT FRACTURE OF RADIUS
25520	2	TREAT FRACTURE OF RADIUS
25525	6	TREAT FRACTURE OF RADIUS
25526	7	TREAT FRACTURE OF RADIUS
25535	2	TREAT FRACTURE OF ULNA
25545	5	TREAT FRACTURE OF ULNA
25565	2	TREAT FRACTURE RADIUS & ULNA
25574	5	TREAT FRACTURE RADIUS & ULNA
25575	5	TREAT FRACTURE RADIUS/ULNA
25605	3	TREAT FRACTURE RADIUS/ULNA
25611	8	TREAT FRACTURE RADIUS/ULNA
25620	7	TREAT FRACTURE RADIUS/ULNA
25624	4	TREAT WRIST BONE FRACTURE
25628	5	TREAT WRIST BONE FRACTURE
25635	2	TREAT WRIST BONE FRACTURE
25645	5	TREAT WRIST BONE FRACTURE
25660	2	TREAT WRIST DISLOCATION
25670	5	TREAT WRIST DISLOCATION
25671 ¹⁶	2	PIN RADIOULNAR DISLOCATION
25675	2	TREAT WRIST DISLOCATION
25676	4	TREAT WRIST DISLOCATION
25680	4	TREAT WRIST FRACTURE
25685	5	TREAT WRIST FRACTURE
25690	2	TREAT WRIST DISLOCATION
25695	4	TREAT WRIST DISLOCATION

CPT SUBSECTION: ARTHRODESIS

25800	6	FUSION OF WRIST JOINT
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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
25805	7	FUSION/GRAFT OF WRIST JOINT
25810	7	FUSION/GRAFT OF WRIST JOINT
25820	6	FUSION OF HAND BONES
25825	7	FUSE HAND BONES WITH GRAFT
25830 ¹⁹	7	FUSION, RADIOULNAR JNT/ULNA
CPT SUBSECTION: AMPUTATION		
25907	5	AMPUTATION FOLLOW-UP SURGERY
25922	5	AMPUTATE HAND AT WRIST
25929	5	AMPUTATION FOLLOW-UP SURGERY
HANDS AND FINGERS		
CPT SUBSECTION: INCISION		
26011	2	DRAINAGE OF FINGER ABSCESS
26020	4	DRAIN HAND TENDON SHEATH
26025	2	DRAINAGE OF PALM BURSA
CPT SUBSECTION: ARTHRODESIS		
26030	4	DRAINAGE OF PALM BURSA(S)
26034	4	TREAT HAND BONE LESION
26035 ²⁰	6	DECOMPRESS FINGERS/HAND
26037 ²⁰	6	DECOMPRESS FINGERS/HAND
26040	6	RELEASE PALM CONTRACTURE
26045	5	RELEASE PALM CONTRACTURE
26055	4	INCISE FINGER TENDON SHEATH
26060	4	INCISION OF FINGER TENDON
26070	4	EXPLORE/TREAT HAND JOINT
26075	6	EXPLORE/TREAT FINGER JOINT
26080	6	EXPLORE/TREAT FINGER JOINT
CPT SUBSECTION: EXCISION		
26100	4	BIOPSY HAND JOINT LINING
26105	2	BIOPSY FINGER JOINT LINING
26110	2	BIOPSY FINGER JOINT LINING
26115	3	REMOVE HAND LESION SUBCUT
26116	3	REMOVE HAND LESION, DEEP
26117	5	REMOVE TUMOR, HAND/FINGER
26121	7	RELEASE PALM CONTRACTURE
26123	6	RELEASE PALM CONTRACTURE
26125	6	RELEASE PALM CONTRACTURE
26130	5	REMOVE WRIST JOINT LINING
26135	6	REVISE FINGER JOINT, EACH
26140	4	REVISE FINGER JOINT, EACH
26145	5	TENDON EXCISION, PALM/FINGER
26160	4	REMOVE TENDON SHEATH LESION
26170	5	REMOVAL OF PALM TENDON, EACH
26180	5	REMOVAL OF FINGER TENDON
26185 ¹⁹	6	REMOVE FINGER BONE
26200	4	REMOVE HAND BONE LESION

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
26205	5	REMOVE/GRAFT BONE LESION
26210	4	REMOVAL OF FINGER LESION
26215	5	REMOVE/GRAFT FINGER LESION
26230	9	PARTIAL REMOVAL OF HAND BONE
26235	5	PARTIAL REMOVAL, FINGER BONE
26236	5	PARTIAL REMOVAL, FINGER BONE
26250	5	EXTENSIVE HAND SURGERY
26255	5	EXTENSIVE HAND SURGERY
26260	5	EXTENSIVE FINGER SURGERY
26261	5	EXTENSIVE FINGER SURGERY
26262	4	PARTIAL REMOVAL OF FINGER
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
26320	4	REMOVAL OF IMPLANT FROM HAND
CPT SUBSECTION: REPAIR, REVISION AND RECONSTRUCTION		
26350	2	REPAIR FINGER/HAND TENDON
26352	6	REPAIR/GRAFT HAND TENDON
26356	6	REPAIR FINGER/HAND TENDON
26357	6	REPAIR FINGER/HAND TENDON
26358	6	REPAIR/GRAFT HAND TENDON
26370	6	REPAIR FINGER/HAND TENDON
26372	6	REPAIR/GRAFT HAND TENDON
26373	5	REPAIR FINGER/HAND TENDON
26390	6	REVISE HAND/FINGER TENDON
26392	5	REPAIR/GRAFT HAND TENDON
26410	5	REPAIR HAND TENDON
26412	5	REPAIR/GRAFT HAND TENDON
26415	6	EXCISION, HAND/FINGER TENDON
26416 ²	5	GRAFT HAND OR FINGER TENDON
26418	1	REPAIR FINGER TENDON
26420	6	REPAIR/GRAFT FINGER TENDON
26426	5	REPAIR FINGER/HAND TENDON
26428	5	REPAIR/GRAFT FINGER TENDON
26432	5	REPAIR FINGER TENDON
26433	5	REPAIR FINGER TENDON
26434	5	REPAIR/GRAFT FINGER TENDON
26437	5	REALIGNMENT OF TENDONS
26440	5	RELEASE PALM/FINGER TENDON
26442	5	RELEASE PALM & FINGER TENDON
26445	5	RELEASE HAND/FINGER TENDON
26449	5	RELEASE FOREARM/HAND TENDON
26450	5	INCISION OF PALM TENDON
26455	5	INCISION OF FINGER TENDON
26460	5	INCISE HAND/FINGER TENDON
26471	4	FUSION OF FINGER TENDONS
26474	4	FUSION OF FINGER TENDONS
26476	2	TENDON LENGTHENING

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
26477	2	TENDON SHORTENING
26478	2	LENGTHENING OF HAND TENDON
26479	2	SHORTENING OF HAND TENDON
26480	5	TRANSPLANT HAND TENDON
26483	5	TRANSPLANT/GRAFT HAND TENDON
26485	4	TRANSPLANT PALM TENDON
26489	5	TRANSPLANT/GRAFT PALM TENDON
26490	5	REVISE THUMB TENDON
26492	5	TENDON TRANSFER WITH GRAFT
26494	5	HAND TENDON/MUSCLE TRANSFER
26496	5	REVISE THUMB TENDON
26497	5	FINGER TENDON TRANSFER
26498	6	FINGER TENDON TRANSFER
26499	5	REVISION OF FINGER
26500	6	HAND TENDON RECONSTRUCTION
26502	6	HAND TENDON RECONSTRUCTION
26504	6	HAND TENDON RECONSTRUCTION
26508	5	RELEASE THUMB CONTRACTURE
26510	5	THUMB TENDON TRANSFER
26516	2	FUSION OF KNUCKLE JOINT
26517	5	FUSION OF KNUCKLE JOINTS
26518	5	FUSION OF KNUCKLE JOINTS
26520	5	RELEASE KNUCKLE CONTRACTURE
26525	5	RELEASE FINGER CONTRACTURE
26527 ³	7	ARTHROPLASTY, CARPOMETACARPAL JOINT
26530	5	REVISE KNUCKLE JOINT
26531	9	REVISE KNUCKLE WITH IMPLANT
26535	7	REVISE FINGER JOINT
26536	7	REVISE/IMPLANT FINGER JOINT
26540	6	REPAIR HAND JOINT
26541	9	REPAIR HAND JOINT WITH GRAFT
26542	6	REPAIR HAND JOINT WITH GRAFT
26545	6	RECONSTRUCT FINGER JOINT
26546 ¹⁹	6	REPAIR NONUNION HAND
26548	6	RECONSTRUCT FINGER JOINT
26550	4	CONSTRUCT THUMB REPLACEMENT
26551 ^{9, 20}	6	GREAT TOE-HAND TRANSFER
26552 ¹⁰	6	RECONSTRUCTION THUMB WITH TOE
26553 ^{9, 20}	4	SINGLE TRANSFER, TOE-HAND
26554 ^{9, 20}	4	DOUBLE TRANSFER, TOE-HAND
26555	5	POSITIONAL CHANGE OF FINGER
26557 ¹⁰	5	TOE TO FINGER TRANSFER; FIRST STAGE
26558 ¹⁰	4	TOE TO FINGER TRANSFER; EACH DELAY
26559 ¹⁰	4	TOE TO FINGER TRANSFER; SECOND STAGE
26560	4	REPAIR OF WEB FINGER
26561	5	REPAIR OF WEB FINGER

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
26562	6	REPAIR OF WEB FINGER
26565	7	CORRECT METACARPAL FLAW
26567	7	CORRECT FINGER DEFORMITY
26568	5	LENGTHEN METACARPAL/FINGER
26580	7	REPAIR HAND DEFORMITY
26585 ¹⁷	7	REPAIR FINGER DEFORMITY
26587 ²	7	RECONSTRUCT EXTRA FINGER
26590	7	REPAIR FINGER DEFORMITY
26591	5	REPAIR MUSCLES OF HAND
26593	5	RELEASE MUSCLES OF HAND
26596	4	EXCISION CONSTRICTING TISSUE
26597 ¹⁷	5	RELEASE OF SCAR CONTRACTURE
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
26605	1	TREAT METACARPAL FRACTURE
26607	4	TREAT METACARPAL FRACTURE
26608 ¹⁹	6	TREAT METACARPAL FRACTURE
26615	7	TREAT METACARPAL FRACTURE
26645	2	TREAT THUMB FRACTURE
26650	4	TREAT THUMB FRACTURE
26665	6	TREAT THUMB FRACTURE
26675	4	TREAT HAND DISLOCATION
26676	4	PIN HAND DISLOCATION
26685	5	TREAT HAND DISLOCATION
26686	5	TREAT HAND DISLOCATION
26705	4	TREAT KNUCKLE DISLOCATION
26706	4	PIN KNUCKLE DISLOCATION
26715	6	TREAT KNUCKLE DISLOCATION
26727	9	TREAT FINGER FRACTURE, EACH
26735	6	TREAT FINGER FRACTURE, EACH
26742	4	TREAT FINGER FRACTURE, EACH
26746	7	TREAT FINGER FRACTURE, EACH
26756	4	PIN FINGER FRACTURE, EACH
26765	6	TREAT FINGER FRACTURE, EACH
26776	4	PIN FINGER DISLOCATION
26785	4	TREAT FINGER DISLOCATION
CPT SUBSECTION: ARTHRODESIS		
26820	7	THUMB FUSION WITH GRAFT
26841	6	FUSION OF THUMB
26842	6	THUMB FUSION WITH GRAFT
26843	5	FUSION OF HAND JOINT
26844	5	FUSION/GRAFT OF HAND JOINT
26850	6	FUSION OF KNUCKLE
26852	6	FUSION OF KNUCKLE WITH GRAFT
26860	5	FUSION OF FINGER JOINT
26861	4	FUSION OF FINGER JNT, ADD-ON
26862	6	FUSION/GRAFT OF FINGER JOINT

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
26863	5	FUSE/GRAFT ADDED JOINT
CPT SUBSECTION: AMPUTATION		
26910	5	AMPUTATE METACARPAL BONE
26951	1	AMPUTATION OF FINGER/THUMB
26952	6	AMPUTATION OF FINGER/THUMB
PELVIS AND HIP JOINT		
CPT SUBSECTION: INCISION		
26990	2	DRAINAGE OF PELVIS LESION
26991	2	DRAINAGE OF PELVIS BURSA
26992 ²⁰	4	DRAINAGE OF BONE LESION
27000	4	INCISION OF HIP TENDON
27001	5	INCISION OF HIP TENDON
27003	5	INCISION OF HIP TENDON
27030 ²⁰	5	DRAINAGE OF HIP JOINT
27033	5	EXPLORATION OF HIP JOINT
27035	6	DENERVATION OF HIP JOINT
CPT SUBSECTION: EXCISION		
27040	2	BIOPSY OF SOFT TISSUES
27041	4	BIOPSY OF SOFT TISSUES
27047	4	REMOVE HIP/PELVIS LESION
27048	5	REMOVE HIP/PELVIS LESION
27049	5	REMOVE TUMOR, HIP/PELVIS
27050	5	BIOPSY OF SACROILIAC JOINT
27052	5	BIOPSY OF HIP JOINT
27060	7	REMOVAL OF ISCHIAL BURSA
27062	7	REMOVE FEMUR LESION/BURSA
27065	7	REMOVAL OF HIP BONE LESION
27066	7	REMOVAL OF HIP BONE LESION
27067 ¹⁹	7	REMOVE/GRAFT HIP BONE LESION
27080	4	REMOVAL OF TAIL BONE
CPT SUBSECTION: PRODUCTION AND/OR REMOVAL		
27086	2	REMOVE HIP FOREIGN BODY
27087	5	REMOVE HIP FOREIGN BODY
CPT SUBSECTION: REPAIR, REVISION AND RECONSTRUCTION		
27097	5	REVISION OF HIP TENDON
27098	5	TRANSFER TENDON TO PELVIS
27100	6	TRANSFER OF ABDOMINAL MUSCLE
27105	6	TRANSFER OF SPINAL MUSCLE
27110	6	TRANSFER OF ILIOPSOAS MUSCLE
27111	6	TRANSFER OF ILIOPSOAS MUSCLE
CPT SUBSECTION: FRACTURES AND/OR DISLOCATIONS		
27193	2	TREAT PELVIC RING FRACTURE
27194	4	TREAT PELVIC RING FRACTURE
27202	4	TREAT TAIL BONE FRACTURE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
27230	2	TREAT THIGH FRACTURE
27238	2	TREAT THIGH FRACTURE
27246	2	TREAT THIGH FRACTURE
27250	2	TREAT HIP DISLOCATION
27252	2	TREAT HIP DISLOCATION
27257 ¹⁹	5	TREAT HIP DISLOCATION
27265	2	TREAT HIP DISLOCATION
27266	4	TREAT HIP DISLOCATION

CPT SUBSECTION: MANIPULATION

27275	4	MANIPULATION OF HIP JOINT
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FEMUR (THIGH REGION) AND KNEE JOINT

CPT SUBSECTION: INCISION

27301	5	DRAIN THIGH/KNEE LESION
27303 ²⁰	4	DRAINAGE OF BONE LESION
27305	4	INCISE THIGH TENDON & FASCIA
27306	5	INCISION OF THIGH TENDON
27307	5	INCISION OF THIGH TENDONS
27310	6	EXPLORATION OF KNEE JOINT
27315	4	PARTIAL REMOVAL, THIGH NERVE
27320	4	PARTIAL REMOVAL, THIGH NERVE

CPT SUBSECTION: EXCISION

27323	2	BIOPSY, THIGH SOFT TISSUES
27324	2	BIOPSY, THIGH SOFT TISSUES
27327	4	REMOVAL OF THIGH LESION
27328	5	REMOVAL OF THIGH LESION
27329 ¹⁹	6	REMOVE TUMOR, THIGH/KNEE
27330	6	BIOPSY, KNEE JOINT LINING
27331	6	EXPLORE/TREAT KNEE JOINT
27332	6	REMOVAL OF KNEE CARTILAGE
27333	6	REMOVAL OF KNEE CARTILAGE
27334	6	REMOVE KNEE JOINT LINING
27335	6	REMOVE KNEE JOINT LINING
27340	5	REMOVAL OF KNEECAP BURSA
27345	9	REMOVAL OF KNEE CYST
27347 ¹⁹	6	REMOVE KNEE CYST
27350	6	REMOVAL OF KNEECAP
27355	5	REMOVE FEMUR LESION
27356	6	REMOVE FEMUR LESION/GRAFT
27357 ¹⁹	7	REMOVE FEMUR LESION/GRAFT
27358 ¹⁹	7	REMOVE FEMUR LESION/FIXATION
27360	7	PARTIAL REMOVAL, LEG BONE(S)

CPT SUBSECTION: INTRODUCTION AND/OR REMOVAL

27372	9	REMOVAL OF FOREIGN BODY
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CPT SUBSECTION: REPAIR, REVISION AND RECONSTRUCTION

27380	2	REPAIR OF KNEECAP TENDON
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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
27381	5	REPAIR/GRAFT KNEECAP TENDON
27385	5	REPAIR OF THIGH MUSCLE
27386	5	REPAIR/GRAFT OF THIGH MUSCLE
27390	2	INCISION OF THIGH TENDON
27391	4	INCISION OF THIGH TENDONS
27392	5	INCISION OF THIGH TENDONS
27393	4	LENGTHENING OF THIGH TENDON
27394	5	LENGTHENING OF THIGH TENDONS
27395	5	LENGTHENING OF THIGH TENDONS
27396	5	TRANSPLANT OF THIGH TENDON
27397	5	TRANSPLANTS OF THIGH TENDONS
27400	5	REVISE THIGH MUSCLES/TENDONS
27403	6	REPAIR OF KNEE CARTILAGE
27405	6	REPAIR OF KNEE LIGAMENT
27407	6	REPAIR OF KNEE LIGAMENT
27409	6	REPAIR OF KNEE LIGAMENTS
27418	5	REPAIR DEGENERATED KNEECAP
27420	5	REVISION OF UNSTABLE KNEECAP
27422	9	REVISION OF UNSTABLE KNEECAP
27424	5	REVISION/REMOVAL OF KNEECAP
27425	9	LATERAL RETINACULAR RELEASE
27427	5	RECONSTRUCTION, KNEE
27428	6	RECONSTRUCTION, KNEE
27429	6	RECONSTRUCTION, KNEE
27430	6	REVISION OF THIGH MUSCLES
27435	6	INCISION OF KNEE JOINT
27437	6	REVISE KNEECAP
27438	7	REVISE KNEECAP WITH IMPLANT
27440 ²⁰	7	REVISION OF KNEE JOINT
27441	7	REVISION OF KNEE JOINT
27442	7	REVISION OF KNEE JOINT
27443	7	REVISION OF KNEE JOINT
27496 ¹⁹	7	DECOMPRESSION OF THIGH/KNEE
27497 ¹⁹	5	DECOMPRESSION OF THIGH/KNEE
27498 ¹⁹	5	DECOMPRESSION OF THIGH/KNEE
27499 ¹⁹	5	DECOMPRESSION OF THIGH/KNEE
CPT SUBSECTION: FRACTURES AND/OR DISLOCATIONS		
27500	2	TREATMENT OF THIGH FRACTURE
27501	4	TREATMENT OF THIGH FRACTURE
27502	4	TREATMENT OF THIGH FRACTURE
27503	5	TREATMENT OF THIGH FRACTURE
27507 ²⁰	6	TREATMENT OF THIGH FRACTURE
27508	2	TREATMENT OF THIGH FRACTURE
27509	5	TREATMENT OF THIGH FRACTURE
27510	2	TREATMENT OF THIGH FRACTURE
27511 ²⁰	6	TREATMENT OF THIGH FRACTURE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
27513 ²⁰	7	TREATMENT OF THIGH FRACTURE
27516	2	TREAT THIGH FX GROWTH PLATE
27517	2	TREAT THIGH FX GROWTH PLATE
27520	2	TREAT KNEECAP FRACTURE
27524 ²⁰	5	TREAT KNEECAP FRACTURE
27530	2	TREAT KNEE FRACTURE
27532	2	TREAT KNEE FRACTURE
27535 ²⁰	5	TREAT KNEE FRACTURE
27538	2	TREAT KNEE FRACTURE(S)
27550	2	TREAT KNEE DISLOCATION
27552	2	TREAT KNEE DISLOCATION
27560	1	TREAT KNEECAP DISLOCATION
27562	2	TREAT KNEECAP DISLOCATION
27566	4	TREAT KNEECAP DISLOCATION
CPT SUBSECTION: MANIPULATION		
27570	2	FIXATION OF KNEE JOINT
CPT SUBSECTION: AMPUTATION		
27594 ¹⁹	5	AMPUTATION FOLLUP-UP SURGERY
LEG (TIBIA AND FIBULA) AND ANKLE JOINT		
CPT SUBSECTION: INCISION		
27600 ¹⁹	5	DECOMPRESSION OF LOWER LEG
27601 ¹⁹	5	DECOMPRESSION OF LOWER LEG
27602 ¹⁹	5	DECOMPRESSION OF LOWER LEG
27603	4	DRAIN LOWER LEG LESION
27604	4	DRAIN LOWER LEG BURSA
27605	2	INCISION OF ACHILLES TENDON
27606	2	INCISION OF ACHILLES TENDON
27607	4	TREAT LOWER LEG BONE LESION
27610	4	EXPLORE/TREAT ANKLE JOINT
27612	5	EXPLORATION OF ANKLE JOINT
CPT SUBSECTION: EXCISION		
27613 ²⁰	2	BIOPSY LOWER LEG SOFT TISSUE
27614	4	BIOPSY LOWER LEG SOFT TISSUE
27615	5	REMOVE TUMOR, LOWER LEG
27618	4	REMOVE LOWER LEG LESION
27619	5	REMOVE LOWER LEG LESION
27620	6	EXPLORE/TREAT ANKLE JOINT
27625	6	REMOVE ANKLE JOINT LINING
27626	6	REMOVE ANKLE JOINT LINING
27630	5	REMOVAL OF TENDON LESION
27635	5	REMOVE LOWER LEG BONE LESION
27637	5	REMOVE/GRAFT LEG BONE LESION
27638	5	REMOVE/GRAFT LEG BONE LESION
27640	4	PARTIAL REMOVAL OF TIBIA
27641	4	PARTIAL REMOVAL OF FIBULA

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
27647 ¹⁹	5	EXTENSIVE ANKLE/HEEL SURGERY
CPT SUBSECTION: REPAIR, REVISION OR RECONSTRUCTION		
27650	5	REPAIR ACHILLES TENDON
27652	5	REPAIR/GRAFT ACHILLES TENDON
27654	5	REPAIR OF ACHILLES TENDON
27656	4	REPAIR LEG FASCIA DEFECT
27658	2	REPAIR OF LEG TENDON, EACH
27659	4	REPAIR OF LEG TENDON, EACH
27664	4	REPAIR OF LEG TENDON, EACH
27665	4	REPAIR OF LEG TENDON, EACH
27675	4	REPAIR LOWER LEG TENDONS
27676	5	REPAIR LOWER LEG TENDONS
27680	5	RELEASE OF LOWER LEG TENDON
27681	4	RELEASE OF LOWER LEG TENDONS
27685	5	REVISION OF LOWER LEG TENDON
27686	5	REVISE LOWER LEG TENDONS
27687	5	REVISION OF CALF TENDON
27690	6	REVISE LOWER LEG TENDON
27691	6	REVISE LOWER LEG TENDON
27692	5	REVISE ADDITIONAL LEG TENDON
27695	4	REPAIR OF ANKLE LIGAMENT
27696	4	REPAIR OF ANKLE LIGAMENTS
27698	4	REPAIR OF ANKLE LIGAMENT
27700	7	REVISION OF ANKLE JOINT
27704	4	REMOVAL OF ANKLE IMPLANT
27705	4	INCISION OF TIBIA
27707	4	INCISION OF FIBULA
27709	4	INCISION OF TIBIA & FIBULA
27715 ²⁰	6	REVISION OF LOWER LEG
27730	4	REPAIR OF TIBIA EPIPHYSIS
27732	4	REPAIR OF FIBULA EPIPHYSIS
27734	4	REPAIR LOWER LEG EPIPHYSES
27740	4	REPAIR OF LEG EPIPHYSES
27742	4	REPAIR OF LEG EPIPHYSES
27745	5	REINFORCE TIBIA
CPT SUBSECTION: FRACTURES AND/OR DISLOCATIONS		
27750	1	TREATMENT OF TIBIA FRACTURE
27752	2	TREATMENT OF TIBIA FRACTURE
27756	5	TREATMENT OF TIBIA FRACTURE
27758	6	TREATMENT OF TIBIA FRACTURE
27759	6	TREATMENT OF TIBIA FRACTURE
27760	1	TREATMENT OF ANKLE FRACTURE
27762	2	TREATMENT OF ANKLE FRACTURE
27766	5	TREATMENT OF ANKLE FRACTURE
27780	2	TREATMENT OF FIBULA FRACTURE
27781	2	TREATMENT OF FIBULA FRACTURE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
27784	5	TREATMENT OF FIBULA FRACTURE
27786	1	TREATMENT OF ANKLE FRACTURE
27788	2	TREATMENT OF ANKLE FRACTURE
27792	5	TREATMENT OF ANKLE FRACTURE
27808	2	TREATMENT OF ANKLE FRACTURE
27810	2	TREATMENT OF ANKLE FRACTURE
27814	5	TREATMENT OF ANKLE FRACTURE
27816	2	TREATMENT OF ANKLE FRACTURE
27818	2	TREATMENT OF ANKLE FRACTURE
27822	5	TREATMENT OF ANKLE FRACTURE
27823	5	TREATMENT OF ANKLE FRACTURE
27824	2	TREAT LOWER LEG FRACTURE
27825	4	TREAT LOWER LEG FRACTURE
27826	5	TREAT LOWER LEG FRACTURE
27827	5	TREAT LOWER LEG FRACTURE
27828	6	TREAT LOWER LEG FRACTURE
27829	4	TREAT LOWER LEG JOINT
27830	2	TREAT LOWER LEG DISLOCATION
27831	2	TREAT LOWER LEG DISLOCATION
27832	4	TREAT LOWER LEG DISLOCATION
27840	2	TREAT ANKLE DISLOCATION
27842	2	TREAT ANKLE DISLOCATION
27846	5	TREAT ANKLE DISLOCATION
27848	5	TREAT ANKLE DISLOCATION
CPT SUBSECTION: MANIPULATION		
27860	2	FIXATION OF ANKLE JOINT
CPT SUBSECTION: ARTHRODESIS		
27870	6	FUSION OF ANKLE JOINT
27871	6	FUSION OF TIBIOFIBULAR JOINT
CPT SUBSECTION: AMPUTATION		
27884	5	AMPUTATION FOLLOW-UP SURGERY
27889 ¹⁹	5	AMPUTATION OF FOOT AT ANKLE
CPT SUBSECTION: OTHER PROCEDURES		
27892 ¹⁹	5	DECOMPRESSION OF LEG
27893 ¹⁹	5	DECOMPRESSION OF LEG
27894 ¹⁹	5	DECOMPRESSION OF LEG
Foot		
CPT SUBSECTION: INCISION		
28002	5	TREATMENT OF FOOT INFECTION
28003	5	TREATMENT OF FOOT INFECTION
28005	5	TREAT FOOT BONE LESION
28008	5	INCISION OF FOOT FASCIA
28011 ¹⁹	5	INCISION OF TOE TENDONS
28020	4	EXPLORATION OF FOOT JOINT
28022 ¹⁹	4	EXPLORATION OF FOOT JOINT

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
28024 ¹⁹	4	EXPLORATION OF TOE JOINT
28030	6	REMOVAL OF FOOT NERVE
28035	6	DECOMPRESSION OF TIBIA NERVE
CPT SUBSECTION: EXCISION		
28043	4	EXCISION OF FOOT LESION
28045	6	EXCISION OF FOOT LESION
28046	5	RESECTION OF TUMOR, FOOT
28050	4	BIOPSY OF FOOT JOINT LINING
28052 ¹⁹	4	BIOPSY OF FOOT JOINT LINING
28054	4	BIOPSY OF TOE JOINT LINING
28060	4	PARTIAL REMOVAL, FOOT FASCIA
28062	5	REMOVAL OF FOOT FASCIA
28070	5	REMOVAL OF FOOT JOINT LINING
28072	5	REMOVAL OF FOOT JOINT LINING
28080	7	REMOVAL OF FOOT LESION
28086	4	EXCISE FOOT TENDON SHEATH
28088	4	EXCISE FOOT TENDON SHEATH
28090	6	REMOVAL OF FOOT LESION
28092	5	REMOVAL OF TOE LESIONS
28100	4	REMOVAL OF ANKLE/HEEL LESION
28102	5	REMOVE/GRAFT FOOT LESION
28103	5	REMOVE/GRAFT FOOT LESION
28104	4	REMOVAL OF FOOT LESION
28106	5	REMOVE/GRAFT FOOT LESION
28107	5	REMOVE/GRAFT FOOT LESION
28110	5	PART REMOVAL OF METATARSAL
28111	5	PART REMOVAL OF METATARSAL
28112	5	PART REMOVAL OF METATARSAL
28113	5	PART REMOVAL OF METATARSAL
28114	5	REMOVAL OF METATARSAL HEADS
28116	5	REVISION OF FOOT
28118	6	REMOVAL OF HEEL BONE
28119	8	REMOVAL OF HEEL SPUR
28120	9	PART REMOVAL OF ANKLE/HEEL
28122	5	PARTIAL REMOVAL OF FOOT BONE
28126 ¹⁹	5	PARTIAL REMOVAL OF TOE
28130	5	REMOVAL OF ANKLE BONE
28140	5	REMOVAL OF METATARSAL
28150	5	REMOVAL OF TOE
28153 ¹⁹	5	PARTIAL REMOVAL OF TOE
28160 ¹⁹	5	PARTIAL REMOVAL OF TOE
28171	5	EXTENSIVE FOOT SURGERY
28173	5	EXTENSIVE FOOT SURGERY
28175	5	EXTENSIVE FOOT SURGERY
28192	4	REMOVAL OF FOOT FOREIGN BODY
28193	6	REMOVAL OF FOOT FOREIGN BODY

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: REPAIR, REVISION OR RECONSTRUCTION		
28200	5	REPAIR OF FOOT TENDON
28202	5	REPAIR/GRAFT OF FOOT TENDON
28208	5	REPAIR OF FOOT TENDON
28210	5	REPAIR/GRAFT OF FOOT TENDON
28222	2	RELEASE OF FOOT TENDONS
28225	2	RELEASE OF FOOT TENDON
28226	2	RELEASE OF FOOT TENDONS
28234 ¹⁹	4	INCISION OF FOOT TENDON
28236 ⁷	4	TRANSFER OF TENDON, ANTERIOR TIBIAL INTO TARSAL BONE
28238	5	REVISION OF FOOT TENDON
28240	4	RELEASE OF BIG TOE
28250	5	REVISION OF FOOT FASCIA
28260	5	RELEASE OF MIDFOOT JOINT
28261	5	REVISION OF FOOT TENDON
28262	6	REVISION OF FOOT AND ANKLE
28264	2	RELEASE OF MIDFOOT JOINT
28270 ¹⁹	5	RELEASE OF FOOT CONTRACTURE
28280	4	FUSION OF TOES
28285	7	REPAIR OF HAMMERTOES
28286	6	REPAIR OF HAMMERTOES
28288	7	PARTIAL REMOVAL OF FOOT BONE
28289 ¹⁹	5	REPAIR HALLUX RIGIDUS
28290	6	CORRECTION OF BUNION
28292	7	CORRECTION OF BUNION
28293	5	CORRECTION OF BUNION
28294	5	CORRECTION OF BUNION
28296	9	CORRECTION OF BUNION
28297	5	CORRECTION OF BUNION
28298	5	CORRECTION OF BUNION
28299	7	CORRECTION OF BUNION
28300	4	INCISION OF HEEL BONE
28302	4	INCISION OF ANKLE BONE
28304	4	INCISION OF MIDFOOT BONES
28305	5	INCISE/GRAFT MIDFOOT BONES
28306	6	INCISION OF METATARSAL
28307 ²	6	INCISION OF METATARSAL
28308	7	INCISION OF METATARSAL
28309	6	INCISION OF METATARSALS
28310	5	REVISION OF BIG TOE
28312	5	REVISION OF TOE
28313	4	REPAIR DEFORMITY OF TOE
28315	6	REMOVAL OF SESAMOID BONE
28320	6	REPAIR OF FOOT BONES
28322	6	REPAIR OF METATARSALS

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
28340 ²	6	RESECT ENLARGED TOE TISSUE
28341 ²	6	RESECT ENLARGED TOE
28344 ²	6	REPAIR EXTRA TOE(S)
28345 ²	6	REPAIR WEBBED TOE(S)
CPT SUBSECTION: FRACTURES AND/OR DISLOCATIONS		
28400	2	TREATMENT OF HEEL FRACTURE
28405	4	TREATMENT OF HEEL FRACTURE
28406	4	TREATMENT OF HEEL FRACTURE
28415	5	TREAT HEEL FRACTURE
28420	6	TREAT/GRAFT HEEL FRACTURE
28435	4	TREATMENT OF ANKLE FRACTURE
28436	4	TREATMENT OF ANKLE FRACTURE
28445	5	TREAT ANKLE FRACTURE
28456 ²	4	TREAT MIDFOOT FRACTURE
28465	5	TREAT MIDFOOT FRACTURE, EACH
28476	4	TREAT METATARSAL FRACTURE
28485	6	TREAT METATARSAL FRACTURE
28496	4	TREAT BIG TOE FRACTURE
28505	5	TREAT BIG TOE FRACTURE
28525	5	TREAT TOE FRACTURE
28531 ¹⁹	5	TREAT SESAMOID BONE FRACTURE
28545	2	TREAT FOOT DISLOCATION
28546	4	TREAT FOOT DISLOCATION
28555	4	REPAIR FOOT DISLOCATION
28575	2	TREAT FOOT DISLOCATION
28576	5	TREAT FOOT DISLOCATION
28585	5	REPAIR FOOT DISLOCATION
28605	2	TREAT FOOT DISLOCATION
28606	4	TREAT FOOT DISLOCATION
28615	5	REPAIR FOOT DISLOCATION
28635	2	TREAT TOE DISLOCATION
28636	5	TREAT TOE DISLOCATION
28645	5	REPAIR TOE DISLOCATION
28665	2	TREAT TOE DISLOCATION
28666	5	TREAT TOE DISLOCATION
28675	5	REPAIR OF TOE DISLOCATION
CPT SUBSECTION: ARTHRODESIS		
28705	6	FUSION OF FOOT BONES
28715	6	FUSION OF FOOT BONES
28725	6	FUSION OF FOOT BONES
28730	6	FUSION OF FOOT BONES
28735	6	FUSION OF FOOT BONES
28737	7	REVISION OF FOOT BONES
28740	6	FUSION OF FOOT BONES
28750	6	FUSION OF BIG TOE JOINT
28755	6	FUSION OF BIG TOE JOINT

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
28760	6	FUSION OF BIG TOE JOINT
CPT SUBSECTION: AMPUTATION		
28810	4	AMPUTATION TOE & METATARSAL
28820	4	AMPUTATION OF TOE
28825	4	PARTIAL AMPUTATION OF TOE
CPT SUBSECTION: ARTHROSCOPY		
29800 ¹⁹	5	JAW ARTHROSCOPY/SURGERY
29804 ²	5	JAW ARTHROSCOPY/SURGERY
29805 ¹⁶	5	SHOULDER ARTHROSCOPY, DX
29806 ¹⁶	5	SHOULDER ARTHROSCOPY/SURGERY
29807 ¹⁶	5	SHOULDER ARTHROSCOPY/SURGERY
29815 ¹⁷	5	SHOULDER ARTHROSCOPY
29819	5	SHOULDER ARTHROSCOPY/SURGERY
29820	5	SHOULDER ARTHROSCOPY/SURGERY
29821	5	SHOULDER ARTHROSCOPY/SURGERY
29822	5	SHOULDER ARTHROSCOPY/SURGERY
29823	5	SHOULDER ARTHROSCOPY/SURGERY
29824 ¹⁶	7	SHOULDER ARTHROSCOPY/SURGERY
29825	5	SHOULDER ARTHROSCOPY/SURGERY
29826	10	SHOULDER ARTHROSCOPY/SURGERY
29827 ¹⁹	7	ARTHROSCOPY ROTATOR CUFF REPR
29830	5	ELBOW ARTHROSCOPY
29834	5	ELBOW ARTHROSCOPY/SURGERY
29835	5	ELBOW ARTHROSCOPY/SURGERY
29836	5	ELBOW ARTHROSCOPY/SURGERY
29837	5	ELBOW ARTHROSCOPY/SURGERY
29838	5	ELBOW ARTHROSCOPY/SURGERY
29840	5	WRIST ARTHROSCOPY
29843	5	WRIST ARTHROSCOPY/SURGERY
29844	5	WRIST ARTHROSCOPY/SURGERY
29845	5	WRIST ARTHROSCOPY/SURGERY
29846	5	WRIST ARTHROSCOPY/SURGERY
29847	5	WRIST ARTHROSCOPY/SURGERY
29848 ¹⁹	10	WRIST ENDOSCOPY/SURGERY
29850	6	KNEE ARTHROSCOPY/SURGERY
29851	6	KNEE ARTHROSCOPY/SURGERY
29855	6	TIBIAL ARTHROSCOPY/SURGERY
29856	6	TIBIAL ARTHROSCOPY/SURGERY
29860 ¹⁹	6	HIP ARTHROSCOPY, DX
29861 ¹⁹	6	HIP ARTHROSCOPY/SURGERY
29862 ¹⁹	10	HIP ARTHROSCOPY/SURGERY
29863 ¹⁹	6	HIP ARTHROSCOPY/SURGERY
29870	9	KNEE ARTHROSCOPY, DX
29871	5	KNEE ARTHROSCOPY/DRAINAGE
29874	9	KNEE ARTHROSCOPY/SURGERY
29875	9	KNEE ARTHROSCOPY/SURGERY

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
29876	10	KNEE ARTHROSCOPY/SURGERY
29877	9	KNEE ARTHROSCOPY/SURGERY
29879	9	KNEE ARTHROSCOPY/SURGERY
29880	10	KNEE ARTHROSCOPY/SURGERY
29881	9	KNEE ARTHROSCOPY/SURGERY
29882	5	KNEE ARTHROSCOPY/SURGERY
29883	5	KNEE ARTHROSCOPY/SURGERY
29884	5	KNEE ARTHROSCOPY/SURGERY
29885	5	KNEE ARTHROSCOPY/SURGERY
29886	5	KNEE ARTHROSCOPY/SURGERY
29887	5	KNEE ARTHROSCOPY/SURGERY
29888	5	KNEE ARTHROSCOPY/SURGERY
29889	5	KNEE ARTHROSCOPY/SURGERY
29891 ¹⁹	5	ANKLE ARTHROSCOPY/SURGERY
29892 ¹⁹	5	ANKLE ARTHROSCOPY/SURGERY
29893 ¹⁹	10	SCOPE, PLANTAR FASCIOTOMY
29894	5	ANKLE ARTHROSCOPY/SURGERY
29895	5	ANKLE ARTHROSCOPY/SURGERY
29897	5	ANKLE ARTHROSCOPY/SURGERY
29898	5	ANKLE ARTHROSCOPY/SURGERY
29899 ¹⁹	5	ANKLE ARTHROSCOPY/SURGERY
29900 ¹⁶	5	MCP JOINT ARTHROSCOPY, DX
29901 ¹⁶	5	MCP JOINT ARTHROSCOPY, SURG
29902 ¹⁶	5	MCP JOINT ARTHROSCOPY, SURG

RESPIRATORY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
Nose		
CPT SUBSECTION: EXCISION		
30115	4	REMOVAL OF NOSE POLYP(S)
30117	5	REMOVAL OF INTRANASAL LESION
30118	5	REMOVAL OF INTRANASAL LESION
30120	3	REVISION OF NOSE
30124 ²⁰	2	REMOVAL OF NOSE LESION
30125	4	REMOVAL OF NOSE LESION
30130	5	REMOVAL OF TURBINATE BONES
30140	4	REMOVAL OF TURBINATE BONES
30150	5	PARTIAL REMOVAL OF NOSE
30160	6	REMOVAL OF NOSE
CPT SUBSECTION: REMOVAL FOREIGN BODY		
30310	2	REMOVE NASAL FOREIGN BODY
30320	4	REMOVE NASAL FOREIGN BODY
CPT SUBSECTION: REPAIR		
30400	6	RECONSTRUCTION OF NOSE

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RESPIRATORY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
30410	7	RECONSTRUCTION OF NOSE
30420	9	RECONSTRUCTION OF NOSE
30430	5	REVISION OF NOSE
30435	7	REVISION OF NOSE
30450	9	REVISION OF NOSE
30460 ¹⁹	9	REVISION OF NOSE
30462 ¹⁹	10	REVISION OF NOSE
30465 ¹⁹	10	REPAIR NASAL STENOSIS
30520	8	REPAIR OF NASAL SEPTUM
30540	7	REPAIR NASAL DEFECT
30545 ¹⁹	7	REPAIR NASAL DEFECT
30560	4	RELEASE OF NASAL ADHESIONS
30580	6	REPAIR UPPER JAW FISTULA
30600	6	REPAIR MOUTH/NOSE FISTULA
30620	9	INTRANASAL RECONSTRUCTION
30630	9	REPAIR NASAL SEPTUM DEFECT
30801	2	CAUTERIZATION, INNER NOSE
30802	2	CAUTERIZATION, INNER NOSE
CPT SUBSECTION: OTHER PROCEDURES		
30903	1	CONTROL OF NOSEBLEED
30905	1	CONTROL OF NOSEBLEED
30906	2	REPEAT CONTROL OF NOSEBLEED
30915	4	LIGATION, NASAL SINUS ARTERY
30920	5	LIGATION, UPPER JAW ARTERY
30930 ¹⁹	6	THERAPY FRACTURE OF NOSE
ACCESSORY SINUSES		
CPT SUBSECTION: INCISION		
31020	4	EXPLORATION, MAXILLARY SINUS
31030	5	EXPLORATION, MAXILLARY SINUS
31032	6	EXPLORE SINUS,REMOVE POLYPS
31050	4	EXPLORATION, SPHENOID SINUS
31051	6	SPHENOID SINUS SURGERY
31070	4	EXPLORATION OF FRONTAL SINUS
31075	6	EXPLORATION OF FRONTAL SINUS
31080	6	REMOVAL OF FRONTAL SINUS
31081 ¹⁹	6	REMOVAL OF FRONTAL SINUS
31084 ²	6	REMOVAL OF FRONTAL SINUS
31085 ¹⁹	6	REMOVAL OF FRONTAL SINUS
31086	6	REMOVAL OF FRONTAL SINUS
31087 ¹⁹	6	REMOVAL OF FRONTAL SINUS
31090	9	EXPLORATION OF SINUSES
CPT SUBSECTION: EXCISION		
31200	4	REMOVAL OF ETHMOID SINUS
31201	7	REMOVAL OF ETHMOID SINUS
31205	5	REMOVAL OF ETHMOID SINUS

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RESPIRATORY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: ENDOSCOPY		
31233	4	NASAL/SINUS ENDOSCOPY, DX
31235	2	NASAL/SINUS ENDOSCOPY, DX
31237	4	NASAL/SINUS ENDOSCOPY, SURG
31238	2	NASAL/SINUS ENDOSCOPY, SURG
31239	6	NASAL/SINUS ENDOSCOPY, SURG
31240	4	NASAL/SINUS ENDOSCOPY, SURG
31245 ³	5	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH OSTEOMEATAL COMPLEX (OMC) RESECTION AND/OR ANTERIOR ETHMOIDECTOMY, WITH OR WITHOUT REMOVAL OF POLYP(S);
31246 ³	5	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH OSTEOMEATAL COMPLEX (OMC) RESECTION AND/OR ANTERIOR ETHMOIDECTOMY, WITH OR WITHOUT REMOVAL OF POLYP(S); WITH ANTROSTOMY
31247 ³	5	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH OSTEOMEATAL COMPLEX (OMC) RESECTION AND/OR ANTERIOR ETHMOIDECTOMY, WITH OR WITHOUT REMOVAL OF POLYP(S); WITH ANTROSTOMY AND REMOVAL OF ANTRAL MUCOSAL DISEASE
31248 ³	5	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH OSTEOMEATAL COMPLEX (OMC) RESECTION AND/OR ANTERIOR ETHMOIDECTOMY, WITH OR WITHOUT REMOVAL OF POLYP(S); WITH FRONTAL SINUS EXPLORATION
31249 ³	5	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH OSTEOMEATAL COMPLEX (OMC) RESECTION AND/OR ANTERIOR ETHMOIDECTOMY, WITH OR WITHOUT REMOVAL OF POLYP(S); WITH FRONTAL SINUS EXPLORATION AND ANTROSTOMY
31251 ³	5	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH OSTEOMEATAL COMPLEX (OMC) RESECTION AND/OR ANTERIOR ETHMOIDECTOMY, WITH OR WITHOUT REMOVAL OF POLYP(S); WITH FRONTAL SINUS EXPLORATION, ANTROSTOMY, AND REMOVAL OF ANTRAL MUCOSAL DISEASE
31254 ¹	5	REVISION OF ETHMOID SINUS
31255 ¹	7	REMOVAL OF ETHMOID SINUS
31256 ¹	5	EXPLORATION MAXILLARY SINUS
31261 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY (APE), WITH OR WITHOUT REMOVAL OF POLYP(S);
31262 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY (APE), WITH OR WITHOUT REMOVAL OF POLYP(S); WITH ANTROSTOMY

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CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
31264 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY (APE), WITH OR WITHOUT REMOVAL OF POLYP(S); WITH ANTROSTOMY AND REMOVAL OF ANTRAL MUCOSAL DISEASE
31266 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY (APE), WITH OR WITHOUT REMOVAL OF POLYP(S); WITH FRONTAL SINUS EXPLORATION
31267 ¹	5	ENDOSCOPY, MAXILLARY SINUS
31269 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY (APE), WITH OR WITHOUT REMOVAL OF POLYP(S); WITH FRONTAL SINUS EXPLORATION AND ANTROSTOMY
31271 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY (APE), WITH OR WITHOUT REMOVAL OF POLYP(S); WITH FRONTAL SINUS EXPLORATION, ANTROSTOMY, AND REMOVAL OF ANTRAL MUCOSAL DISEASE
31276 ¹	5	SINUS ENDOSCOPY, SURGICAL
31280 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY AND SPHENOIDOTOMY (APS), WITH OR WITHOUT REMOVAL OF POLYP(S);
31281 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY AND SPHENOIDOTOMY (APS), WITH OR WITHOUT REMOVAL OF POLYP(S); WITH ANTROSTOMY
31282 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY AND SPHENOIDOTOMY (APS), WITH OR WITHOUT REMOVAL OF POLYP(S); WITH ANTROSTOMY AND REMOVAL OF ANTRAL MUCOSAL DISEASE
31283 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY AND SPHENOIDOTOMY (APS), WITH OR WITHOUT REMOVAL OF POLYP(S); WITH FRONTAL SINUS EXPLORATION
31284 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY AND SPHENOIDOTOMY (APS), WITH OR WITHOUT REMOVAL OF POLYP(S); WITH FRONTAL SINUS EXPLORATION AND ANTROSTOMY

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RESPIRATORY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
31286 ³	7	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH ANTERIOR AND POSTERIOR ETHMOIDECTOMY AND SPHENOIDOTOMY (APS), WITH OR WITHOUT REMOVAL OF POLYP(S); WITH FRONTAL SINUS EXPLORATION, ANTROSTOMY AND REMOVAL OF ANTRAL MUCOSAL DISEASE
31287	5	NASAL/SINUS ENDOSCOPY, SURG
31288	5	NASAL/SINUS ENDOSCOPY, SURG

LARYNX

CPT SUBSECTION: EXCISION

31300	7	REMOVAL OF LARYNX LESION
31320	4	DIAGNOSTIC INCISION, LARYNX
31400 ¹⁹	4	REVISION OF LARYNX
31420 ¹⁹	4	REMOVAL OF EPIGLOTTIS

CPT SUBSECTION: ENDOSCOPY

31510	4	LARYNGOSCOPY WITH BIOPSY
31511	4	REMOVE FOREIGN BODY, LARYNX
31512	4	REMOVAL OF LARYNX LESION
31513	4	INJECTION INTO VOCAL CORD
31515	2	LARYNGOSCOPY FOR ASPIRATION
31525	2	DIAGNOSTIC LARYNGOSCOPY
31526	4	DIAGNOSTIC LARYNGOSCOPY
31527	2	LARYNGOSCOPY FOR TREATMENT
31528	4	LARYNGOSCOPY AND DILATION
31529	4	LARYNGOSCOPY AND DILATION
31530	4	OPERATIVE LARYNGOSCOPY
31531	5	OPERATIVE LARYNGOSCOPY
31535	6	OPERATIVE LARYNGOSCOPY
31536	6	OPERATIVE LARYNGOSCOPY
31540	6	OPERATIVE LARYNGOSCOPY
31541	7	OPERATIVE LARYNGOSCOPY
31560	7	OPERATIVE LARYNGOSCOPY
31561	7	OPERATIVE LARYNGOSCOPY
31570	4	LARYNGOSCOPY WITH INJECTION
31571	4	LARYNGOSCOPY WITH INJECTION
31576	4	LARYNGOSCOPY WITH BIOPSY
31577	4	REMOVE FOREIGN BODY, LARYNX
31578	4	REMOVAL OF LARYNX LESION
31580	7	REVISION OF LARYNX
31582	7	REVISION OF LARYNX
31584 ²⁰	6	TREAT LARYNX FRACTURE
31585	2	TREAT LARYNX FRACTURE
31586	4	TREAT LARYNX FRACTURE
31588	7	REVISION OF LARYNX
31590	7	REINNERVATE LARYNX

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RESPIRATORY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: DESTRUCTION		
31595	4	LARYNX NERVE SURGERY
TRACHEA AND BRONCHI		
CPT SUBSECTION: INCISION		
31600 ²⁰	4	INCISION OF WINDPIPE
31611	5	SURGERY/SPEECH PROSTHESIS
31612	2	PUNCTURE/CLEAR WINDPIPE
31613	4	REPAIR WINDPIPE OPENING
31614	4	REPAIR WINDPIPE OPENING
CPT SUBSECTION: ENDOSCOPY		
31615	2	VISUALIZATION OF WINDPIPE
31622	4	DX BRONCHOSCOPE/WASH
31623 ¹⁹	4	DX BRONCHOSCOPE/BRUSH
31624 ¹⁹	4	DX BRONCHOSCOPE/LAVAGE
31625	5	BRONCHOSCOPY WITH BIOPSY
31628	6	BRONCHOSCOPY WITH BIOPSY
31629	4	BRONCHOSCOPY WITH BIOPSY
31630	4	BRONCHOSCOPY WITH REPAIR
31631	4	BRONCHOSCOPY WITH DILATION
31635	4	REMOVE FOREIGN BODY, AIRWAY
31640	4	BRONCHOSCOPY & REMOVE LESION
31641	4	BRONCHOSCOPY, TREAT BLOCKAGE
31643 ¹⁹	4	DIAG BRONCHOSCOPE/CATHETER
31645	5	BRONCHOSCOPY, CLEAR AIRWAYS
31646	2	BRONCHOSCOPY, RECLEAR AIRWAY
31656	2	BRONCHOSCOPY, INJ FOR XRAY
31659 ³	2	BRONCHOSCOPY; WITH OTHER BRONCHOSCOPIC PROCEDURES
CPT SUBSECTION: INTRODUCTION		
31700	2	INSERTION OF AIRWAY CATHETER
31710 ²⁰	2	INSERTION OF AIRWAY CATHETER
31715 ²⁰	2	INJECTION FOR BRONCHUS X-RAY
31717	2	BRONCHIAL BRUSH BIOPSY
31720	2	CLEARANCE OF AIRWAYS
31730	2	INTRO, WINDPIPE WIRE/TUBE
CPT SUBSECTION: REPAIR		
31750	7	REPAIR OF WINDPIPE
31755	4	REPAIR OF WINDPIPE
31785 ²⁰	6	REMOVE WINDPIPE LESION
CPT SUBSECTION: SUTURE		
31800 ²⁰	4	REPAIR OF WINDPIPE INJURY
31820	2	CLOSURE OF WINDPIPE LESION
31825	4	REPAIR OF WINDPIPE DEFECT
31830	4	REVISE WINDPIPE SCAR

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RESPIRATORY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
LUNGS AND PLEURA		
CPT SUBSECTION: INCISION		
32000	2	DRAINAGE OF CHEST
32002 ²⁰	4	TREATMENT OF COLLAPSED LUNG
32005 ²⁰	4	TREAT LUNG LINING CHEMICALLY
32020 ²⁰	4	INSERTION OF CHEST TUBE
CPT SUBSECTION: EXCISION		
32400	2	NEEDLE BIOPSY CHEST LINING
32405	5	BIOPSY, LUNG OR MEDIASTINUM
32420	2	PUNCTURE/CLEAR LUNG

CARDIOVASCULAR SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
HEART AND PERICARDIUM		
CPT SUBSECTION: PERICARDIUM		
33010	4	DRAINAGE OF HEART SAC
33011	4	REPEAT DRAINAGE OF HEART SAC
CPT SUBSECTION: PACEMAKER OR PACING CARDIOVERTER-DEFIBRILLATOR		
33222 ¹⁹	4	REVISE POCKET, PACEMAKER
33223 ¹⁹	4	REVISE POCKET, PACING-DEFIB
ARTERIES AND VEINS		
CPT SUBSECTION: ARTERIAL EMBOLECTOMY OR THROMBECTOMY		
34101 ²⁰	5	REMOVAL OF ARTERY CLOT
CPT SUBSECTION: REPAIR ARTERIOVENOUS FISTULA		
35188 ¹⁹	6	REPAIR BLOOD VESSEL LESION
CPT SUBSECTION: REPAIR BLOOD VESSEL OTHER THAN FOR FISTULA, WITH OR WITHOUT PATCH ANGIOPLASTY		
35207 ¹⁹	6	REPAIR BLOOD VESSEL LESION
CPT SUBSECTION: EXPLORATION/REVISION		
35875 ¹⁹	10	REMOVAL OF CLOT IN GRAFT
35876 ¹⁹	10	REMOVAL OF CLOT IN GRAFT
CPT SUBSECTION: INTRA-ARTERIAL-INTRA-AORTIC		
36260 ¹⁹	5	INSERTION OF INFUSION PUMP
36261	4	REVISION OF INFUSION PUMP
36262	2	REMOVAL OF INFUSION PUMP
CPT SUBSECTION: VENOUS		
36488	4	INSERTION OF CATHETER, VEIN
36489	4	INSERTION OF CATHETER, VEIN
36490	5	INSERTION OF CATHETER, VEIN
36491	5	INSERTION OF CATHETER, VEIN
36522 ⁴	4	PHOTOPHERESIS

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CARDIOVASCULAR SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
36530	5	INSERTION OF INFUSION PUMP
36531	4	REVISION OF INFUSION PUMP
36532	2	REMOVAL OF INFUSION PUMP
36533	6	INSERTION OF ACCESS DEVICE
36534	4	REVISION OF ACCESS DEVICE
36535	2	REMOVAL OF ACCESS DEVICE
CPT SUBSECTION: ARTERIAL		
36640	2	INSERTION CATHETER, ARTERY
CPT SUBSECTION: INTERVASCULAR CANNULIZATION OR SHUNT (SEPARATE PROCEDURE)		
36800	5	INSERTION OF CANNULA
36810	5	INSERTION OF CANNULA
36815	5	INSERTION OF CANNULA
36819 ¹⁶	5	AV FUSION/UPPR ARM VEIN
36820 ¹⁶	5	AV FUSION/FOREARM VEIN
36821	5	AV FUSION DIRECT ANY SITE
36825	6	ARTERY-VEIN GRAFT
36830	6	ARTERY-VEIN GRAFT
36831 ¹⁹	10	OPEN THROMBECT AV FISTULA
36832	6	AV FISTULA REVISION, OPEN
36833 ¹³	6	AV FISTULA REVISION
36835	6	ARTERY TO VEIN SHUNT
36840 ³	6	INSERTION MANDRIL
36845 ³	6	ANASTOMOSIS MANDRIL
36860	4	EXTERNAL CANNULA DECLOTTING
36861	5	CANNULA DECLOTTING
36870 ¹⁹	10	PERCUT THROMBECT AV FISTULA
CPT SUBSECTION: LIGATION AND OTHER PROCEDURES		
37607 ¹⁹	5	LIGATION OF A-V FISTULA
37609	4	TEMPORAL ARTERY PROCEDURE
37650 ¹⁹	4	REVISION OF MAJOR VEIN
37700	4	REVISE LEG VEIN
37720	7	REMOVAL OF LEG VEIN
37730	5	REMOVAL OF LEG VEINS
37735	5	REMOVAL OF LEG VEINS/LESION
37760	5	REVISION OF LEG VEINS
37780	5	REVISION OF LEG VEIN
37785	5	REVISE SECONDARY VARICOSITY
37790 ¹⁹	5	PENILE VENOUS OCCLUSION

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HEMIC AND LYMPHATIC SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
NODES AND LYMPHATIC CHANNELS		
CPT SUBSECTION: INCISION		
38300	2	DRAINAGE, LYMPH NODE LESION
38305	4	DRAINAGE, LYMPH NODE LESION
38308	4	INCISION OF LYMPH CHANNELS
CPT SUBSECTION: EXCISION		
38500	3	BIOPSY/REMOVAL, LYMPH NODES
38505	2	NEEDLE BIOPSY, LYMPH NODES
38510	5	BIOPSY/REMOVAL, LYMPH NODES
38520	4	BIOPSY/REMOVAL, LYMPH NODES
38525	6	BIOPSY/REMOVAL, LYMPH NODES
38530	4	BIOPSY/REMOVAL, LYMPH NODES
38542	4	EXPLORE DEEP NODE(S), NECK
38550	5	REMOVAL, NECK/ARMPIT LESION
38555	6	REMOVAL, NECK/ARMPIT LESION
CPT SUBSECTION: LAPAROSCOPY		
38570 ¹⁹	10	LAPAROSCOPY, LYMPH NODE BIOP
38571 ¹⁹	10	LAPAROSCOPY, LYMPHADENECTOMY
38572 ¹⁹	10	LAPAROSCOPY, LYMPHADENECTOMY
CPT SUBSECTION: RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)		
38700 ²⁰	4	REMOVAL OF LYMPH NODES, NECK
38740	4	REMOVE ARMPIT LYMPH NODES
38745	6	REMOVE ARMPIT LYMPH NODES
38760	4	REMOVE GROIN LYMPH NODES
CPT SUBSECTION: INTRODUCTION		
38790 ²⁰	2	INJECT FOR LYMPHATIC X-RAY

DIGESTIVE SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
LIPS		
CPT SUBSECTION: EXCISION		
40500	4	PARTIAL EXCISION OF LIP
40510	4	PARTIAL EXCISION OF LIP
40520	4	PARTIAL EXCISION OF LIP
40525	4	RECONSTRUCT LIP WITH FLAP
40527	4	RECONSTRUCT LIP WITH FLAP
40530	4	PARTIAL REMOVAL OF LIP
CPT SUBSECTION: REPAIR (CHEILOPLASTY)		
40650	5	REPAIR LIP
40652	5	REPAIR LIP
40654	5	REPAIR LIP

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
40700 ¹⁹	9	REPAIR CLEFT LIP/NASAL
40701 ¹⁹	9	REPAIR CLEFT LIP/NASAL
40720 ¹⁹	9	REPAIR CLEFT LIP/NASAL
40761 ¹⁹	5	REPAIR CLEFT LIP/NASAL
VESTIBULE OF MOUTH		
CPT SUBSECTION: INCISION		
40801	4	DRAINAGE OF MOUTH LESION
40805 ²⁰	4	REMOVAL, FOREIGN BODY, MOUTH
40806 ²⁰	2	INCISION OF LIP FOLD
CPT SUBSECTION: EXCISION, DESTRUCTION		
40814	4	EXCISE/REPAIR MOUTH LESION
40816	4	EXCISION OF MOUTH LESION
40818	2	EXCISE ORAL MUCOSA FOR GRAFT
40819	2	EXCISE LIP OR CHEEK FOLD
40820 ²⁰	2	TREATMENT OF MOUTH LESION
CPT SUBSECTION: REPAIR		
40831	2	REPAIR MOUTH LACERATION
40840	4	RECONSTRUCTION OF MOUTH
40842	5	RECONSTRUCTION OF MOUTH
40843	5	RECONSTRUCTION OF MOUTH
40844	7	RECONSTRUCTION OF MOUTH
40845	7	RECONSTRUCTION OF MOUTH
TONGUE, FLOOR OF MOUTH		
CPT SUBSECTION: INCISION		
41000 ²⁰	2	DRAINAGE OF MOUTH LESION
41005	2	DRAINAGE OF MOUTH LESION
41006	2	DRAINAGE OF MOUTH LESION
41007	2	DRAINAGE OF MOUTH LESION
41008	2	DRAINAGE OF MOUTH LESION
41009	2	DRAINAGE OF MOUTH LESION
41010	2	INCISION OF TONGUE FOLD
41015	2	DRAINAGE OF MOUTH LESION
41016	2	DRAINAGE OF MOUTH LESION
41017	2	DRAINAGE OF MOUTH LESION
41018	2	DRAINAGE OF MOUTH LESION
CPT SUBSECTION: EXCISION		
41105 ²⁰	4	BIOPSY OF TONGUE
41110 ²⁰	2	EXCISION OF TONGUE LESION
41112	4	EXCISION OF TONGUE LESION
41113	4	EXCISION OF TONGUE LESION
41114	4	EXCISION OF TONGUE LESION
41115 ²⁰	2	EXCISION OF TONGUE FOLD
41116	2	EXCISION OF MOUTH LESION
41120	7	PARTIAL REMOVAL OF TONGUE

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: REPAIR		
41250	4	REPAIR TONGUE LACERATION
41251	4	REPAIR TONGUE LACERATION
41252	4	REPAIR TONGUE LACERATION
CPT SUBSECTION: OTHER PROCEDURES		
41500	2	FIXATION OF TONGUE
41510	2	TONGUE TO LIP SURGERY
41520	4	RECONSTRUCTION, TONGUE FOLD
DENTOALVEOLAR STRUCTURES		
CPT SUBSECTION: INCISION		
41800	2	DRAINAGE OF GUM LESION
41805 ²⁰	2	REMOVAL FOREIGN BODY, GUM
41806 ²⁰	2	REMOVAL FOREIGN BODY, JAWBONE
CPT SUBSECTION: EXCISION, DESTRUCTION		
41827	4	EXCISION OF GUM LESION
PALATE, UVULA		
CPT SUBSECTION: INCISION		
42000	4	DRAINAGE MOUTH ROOF LESION
CPT SUBSECTION: EXCISION, DESTRUCTION		
42104 ²⁰	4	EXCISION LESION, MOUTH ROOF
42106 ²⁰	4	EXCISION LESION, MOUTH ROOF
42107	4	EXCISION LESION, MOUTH ROOF
42120	6	REMOVE PALATE/LESION
42140	4	EXCISION OF UVULA
42145	7	REPAIR PALATE, PHARYNX/UVULA
42160 ²⁰	2	TREATMENT MOUTH ROOF LESION
CPT SUBSECTION: REPAIR		
42180	2	REPAIR PALATE
42182	4	REPAIR PALATE
42200	7	RECONSTRUCT CLEFT PALATE
42205	7	RECONSTRUCT CLEFT PALATE
42210	7	RECONSTRUCT CLEFT PALATE
42215	9	RECONSTRUCT CLEFT PALATE
42220	7	RECONSTRUCT CLEFT PALATE
42225 ²⁰	7	RECONSTRUCT CLEFT PALATE
42226 ¹⁹	7	LENGTHENING OF PALATE
42235	7	REPAIR PALATE
42260	6	REPAIR NOSE TO LIP FISTULA
42281 ²⁰	5	PREPARATION, PALATE MOLD
SALIVARY GLAND AND DUCTS		
CPT SUBSECTION: INCISION		
42300	2	DRAINAGE OF SALIVARY GLAND
42305	4	DRAINAGE OF SALIVARY GLAND
42310	2	DRAINAGE OF SALIVARY GLAND

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
42320	2	DRAINAGE OF SALIVARY GLAND
42325	4	CREATE SALIVARY CYST DRAIN
42335 ²⁰	5	REMOVAL OF SALIVARY STONE
42340	4	REMOVAL OF SALIVARY STONE
CPT SUBSECTION: EXCISION		
42405	4	BIOPSY OF SALIVARY GLAND
42408	5	EXCISION OF SALIVARY CYST
42409	5	DRAINAGE OF SALIVARY CYST
42410	5	EXCISE PAROTID GLAND/LESION
42415 ¹⁹	9	EXCISE PAROTID GLAND/LESION
42420	9	EXCISE PAROTID GLAND/LESION
42425	9	EXCISE PAROTID GLAND/LESION
42440	5	EXCISE SUBMAXILLARY GLAND
42450	4	EXCISE SUBLINGUAL GLAND
CPT SUBSECTION: REPAIR		
42500	5	REPAIR SALIVARY DUCT
42505	6	REPAIR SALIVARY DUCT
42507	5	PAROTID DUCT DIVERSION
42508	6	PAROTID DUCT DIVERSION
42509	6	PAROTID DUCT DIVERSION
42510	6	PAROTID DUCT DIVERSION
CPT SUBSECTION: OTHER PROCEDURES		
42600	2	CLOSURE OF SALIVARY FISTULA
PHARYNX, ADENOIDS, AND TONSILS		
CPT SUBSECTION: INCISION		
42700	2	DRAINAGE OF TONSIL ABSCESS
42720	2	DRAINAGE OF THROAT ABSCESS
42725	4	DRAINAGE OF THROAT ABSCESS
CPT SUBSECTION: EXCISION, DESTRUCTION		
42802	2	BIOPSY OF THROAT
42804	2	BIOPSY OF UPPER NOSE/THROAT
42806	4	BIOPSY OF UPPER NOSE/THROAT
42808	4	EXCISE PHARYNX LESION
42810	5	EXCISION OF NECK CYST
42815	7	EXCISION OF NECK CYST
42820	6	REMOVE TONSILS AND ADENOIDS
42821	7	REMOVE TONSILS AND ADENOIDS
42825	6	REMOVAL OF TONSILS
42826	6	REMOVAL OF TONSILS
42830	5	REMOVAL OF ADENOIDS
42831	6	REMOVAL OF ADENOIDS
42835	6	REMOVAL OF ADENOIDS
42836	6	REMOVAL OF ADENOIDS
42860	5	EXCISION OF TONSIL TAGS
42870	5	EXCISION OF LINGUAL TONSIL

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
42880 ¹⁰	7	EXCISION NASOPHARYNGEAL LESION (E.G., FIBROMA)
42890 ¹⁹	9	PARTIAL REMOVAL OF PHARYNX
42892 ¹⁹	9	REVISION OF PHARYNGEAL WALLS
CPT SUBSECTION: REPAIR		
42900	2	REPAIR THROAT WOUND
42950	4	RECONSTRUCTION OF THROAT
CPT SUBSECTION: OTHER PROCEDURES		
42955	4	SURGICAL OPENING OF THROAT
42960	2	CONTROL THROAT BLEEDING
42962	4	CONTROL THROAT BLEEDING
42972 ¹⁹	5	CONTROL NOSE/THROAT BLEEDING
ESOPHAGUS		
CPT SUBSECTION: ENDOSCOPY		
43200	1	ESOPHAGUS ENDOSCOPY
43201 ¹⁹	2	ESOPH SCOPE W/ SUBMUCOUS INJ
43202	1	ESOPHAGUS ENDOSCOPY, BIOPSY
43204	1	ESOPHAGUS ENDOSCOPY & INJECT
43205 ¹⁹	2	ESOPHAGUS ENDOSCOPY/LIGATION
43215	1	ESOPHAGUS ENDOSCOPY
43216	2	ESOPHAGUS ENDOSCOPY/LESION
43217	2	ESOPHAGUS ENDOSCOPY
43219	2	ESOPHAGUS ENDOSCOPY
43220	2	ESOPH ENDOSCOPY, DILATION
43226	2	ESOPH ENDOSCOPY, DILATION
43227	4	ESOPH ENDOSCOPY, REPAIR
43228	4	ESOPH ENDOSCOPY, ABLATION
43231 ¹⁹	4	ESOPH ENDOSCOPY W/ US EXAM
43232 ¹⁹	4	ESOPH ENDOSCOPY W/ US FN BX
43234	1	UPPER GI ENDOSCOPY, EXAM
43235	1	UPPR GI ENDOSCOPY, DIAGNOSIS
43236 ¹⁹	4	UPPR GI SCOPY W/ SUBMUC INJ
43239	2	UPPER GI ENDOSCOPY, BIOPSY
43240 ¹⁹	4	ESOPH ENDOSCOPE W/ DRAIN CYST
43241	4	UPPER GI ENDOSCOPY WITH TUBE
43242 ¹⁹	4	UPPR GI ENDOSCOPY W/ US FN BX
43243	4	UPPER GI ENDOSCOPY & INJECT
43244 ¹⁹	4	UPPER GI ENDOSCOPY/LIGATION
43245	2	OPERATIVE UPPER GI ENDOSCOPY
43246	4	PLACE GASTROSTOMY TUBE
43247	3	OPERATIVE UPPER GI ENDOSCOPY
43248	4	UPPR GI ENDOSCOPY/GUIDE WIRE
43249 ⁸	4	ESOPH ENDOSCOPY, DILATION
43250	4	UPPER GI ENDOSCOPY/TUMOR
43251	3	OPERATIVE UPPER GI ENDOSCOPY
43255	4	OPERATIVE UPPER GI ENDOSCOPY

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
43256 ¹⁹	4	UPPR GI ENDOSCOPY W STENT
43258	5	OPERATIVE UPPER GI ENDOSCOPY
43259 ²	5	ENDOSCOPIC ULTRASOUND EXAM
43260	5	ENDO CHOLANGIOPANCREATOGRAPH
43261	4	ENDO CHOLANGIOPANCREATOGRAPH
43262	4	ENDO CHOLANGIOPANCREATOGRAPH
43263	4	ENDO CHOLANGIOPANCREATOGRAPH
43264	4	ENDO CHOLANGIOPANCREATOGRAPH
43265	4	ENDO CHOLANGIOPANCREATOGRAPH
43267	4	ENDO CHOLANGIOPANCREATOGRAPH
43268	4	ENDO CHOLANGIOPANCREATOGRAPH
43269	4	ENDO CHOLANGIOPANCREATOGRAPH
43271	4	ENDO CHOLANGIOPANCREATOGRAPH
43272	4	ENDO CHOLANGIOPANCREATOGRAPH
CPT SUBSECTION: MANIPULATION		
43450	1	DILATE ESOPHAGUS
43453	1	DILATE ESOPHAGUS
43456	4	DILATE ESOPHAGUS
43458	4	DILATE ESOPHAGUS
STOMACH		
CPT SUBSECTION: EXCISION		
43600	2	BIOPSY OF STOMACH
CPT SUBSECTION: LAPAROSCOPY		
43653 ¹⁹	10	LAPAROSCOPY, GASTROSTOMY
CPT SUBSECTION: INTRODUCTION		
43750	4	PLACE GASTROSTOMY TUBE
43760	1	CHANGE GASTROSTOMY TUBE
CPT SUBSECTION: SUTURE		
43870	2	REPAIR STOMACH OPENING
INTESTINES (EXCEPT RECTUM)		
CPT SUBSECTION: EXCISION		
44100	2	BIOPSY OF BOWEL
CPT SUBSECTION: ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES		
44312	2	REVISION OF ILEOSTOMY
44340	5	REVISION OF COLOSTOMY
44345 ²⁰	6	REVISION OF COLOSTOMY
44346 ²⁰	6	REVISION OF COLOSTOMY
CPT SUBSECTION: ENDOSCOPY, SMALL BOWEL AND STOMAL		
44360	4	SMALL BOWEL ENDOSCOPY
44361	4	SMALL BOWEL ENDOSCOPY/BIOPSY
44363	4	SMALL BOWEL ENDOSCOPY
44364	4	SMALL BOWEL ENDOSCOPY
44365	4	SMALL BOWEL ENDOSCOPY
44366	4	SMALL BOWEL ENDOSCOPY

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
44369	4	SMALL BOWEL ENDOSCOPY
44370 ¹⁹	10	SMALL BOWEL ENDOSCOPY/STENT
44372	4	SMALL BOWEL ENDOSCOPY
44373	4	SMALL BOWEL ENDOSCOPY
44376 ¹⁹	4	SMALL BOWEL ENDOSCOPY
44377 ¹⁹	4	SMALL BOWEL ENDOSCOPY/BIOPSY
44378 ¹⁹	4	SMALL BOWEL ENDOSCOPY
44379 ¹⁹	10	S BOWEL ENDOSCOPE W/ STENT
44380	2	SMALL BOWEL ENDOSCOPY
44382	2	SMALL BOWEL ENDOSCOPY
44383 ¹⁹	10	ILEOSCOPY W/ STENT
44385	2	ILEOSCOPY W/ STENT
44386	2	ENDOSCOPY, BOWEL POUCH/BIOP
44388	2	COLON ENDOSCOPY
44389	2	COLONOSCOPY WITH BIOPSY
44390	2	COLONOSCOPY FOR FOREIGN BODY
44391	2	COLONOSCOPY FOR BLEEDING
44392	2	COLONOSCOPY & POLYPECTOMY
44393	2	COLONOSCOPY, LESION REMOVAL
44394	2	COLONOSCOPY W/ SNARE
RECTUM		
CPT SUBSECTION: INCISION		
45000	2	DRAINAGE OF PELVIC ABSCESS
45005	4	DRAINAGE OF RECTAL ABSCESS
45020	4	DRAINAGE OF RECTAL ABSCESS
CPT SUBSECTION: EXCISION		
45100	2	BIOPSY OF RECTUM
45108	4	REMOVAL OF ANORECTAL LESION
45150	4	EXCISION OF RECTAL STRICTURE
45160 ¹⁹	4	EXCISION OF RECTAL LESION
45170	4	EXCISION OF RECTAL LESION
45180 ³	5	EXCISION AND/OR ELECTRODESICCATION OF MALIGNANT TUMOR OF RECTUM, TRANSANAL APPROACH
CPT SUBSECTION: DESTRUCTION		
45190 ¹⁹	10	DESTRUCTION, RECTAL TUMOR
CPT SUBSECTION: ENDOSCOPY		
45305	2	PROTOSIGMOIDOSCOPY W/BX
45307	2	PROTOSIGMOIDOSCOPY FB
45308	2	PROTOSIGMOIDOSCOPY REMOVAL
45309	2	PROTOSIGMOIDOSCOPY REMOVAL
45315	2	PROTOSIGMOIDOSCOPY REMOVAL
45317	2	PROTOSIGMOIDOSCOPY BLEED
45320	2	PROTOSIGMOIDOSCOPY ABLATE
45321	2	PROTOSIGMOIDOSCOPY VOLVUL

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CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
45331	1	SIGMOIDOSCOPY AND BIOPSY
45332	2	SIGMOIDOSCOPY W/FB REMOVAL
45333	2	SIGMOIDOSCOPY & POLYPECTOMY
45334	2	SIGMOIDOSCOPY FOR BLEEDING
45335 ¹⁹	2	SIGMOIDOSCOPE W/SUBMUB INJ
45337	2	SIGMOIDOSCOPY & DECOMPRESS
45338	2	SIGMOIDOSCPY W/TUMR REMOVE
45339	2	SIGMOIDOSCOPY W/ABLATE TUMR
45340 ¹⁹	2	SIG W/BALLOON DILATION
45355	2	SURGICAL COLONOSCOPY
45378	2	DIAGNOSTIC COLONOSCOPY
45379	4	COLONOSCOPY W/FB REMOVAL
45380	3	COLONOSCOPY AND BIOPSY
45381 ¹⁹	4	COLONOSCOPE, SUBMUCOUS INJ
45382	4	COLONOSCOPY/CONTROL BLEEDING
45383	3	LESION REMOVAL COLONOSCOPY
45384	4	LESION REMOVE COLONOSCOPY
45385	3	LESION REMOVAL COLONOSCOPY
45386 ¹⁹	4	COLONOSCOPE DILATE STRICTURE
CPT SUBSECTION: REPAIR		
45500	4	REPAIR OF RECTUM
45505	4	REPAIR OF RECTUM
45560	4	REPAIR OF RECTOCELE
CPT SUBSECTION: MANIPULATION		
45900	2	REDUCTION OF RECTAL PROLAPSE
45905	2	DILATION OF ANAL SPHINCTER
45910	2	DILATION OF RECTAL NARROWING
45915	2	REMOVE RECTAL OBSTRUCTION
ANUS		
CPT SUBSECTION: INCISION		
46020 ¹⁶	5	PLACEMENT OF SETON
46030	2	REMOVAL OF RECTAL MARKER
46040	5	INCISION OF RECTAL ABSCESS
46045	4	INCISION OF RECTAL ABSCESS
46050	2	INCISION OF ANAL ABSCESS
46060	4	INCISION OF RECTAL ABSCESS
46080	5	INCISION OF ANAL SPHINCTER
CPT SUBSECTION: EXCISION		
46200	6	REMOVAL OF ANAL FISSURE
46210	4	REMOVAL OF ANAL CRYPT
46211	4	REMOVAL OF ANAL CRYPTS
46220	2	REMOVAL OF ANAL TAB
46250	5	HEMORRHOIDECTOMY
46255	7	HEMORRHOIDECTOMY
46257	5	REMOVE HEMORRHOIDS & FISSURE

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
46258	5	REMOVE HEMORRHOIDS & FISTULA
46260	9	HEMORRHOIDECTOMY
46261	6	REMOVE HEMORRHOIDS & FISSURE
46262	6	REMOVE HEMORRHOIDS & FISTULA
46270	5	REMOVAL OF ANAL FISTULA
46275	5	REMOVAL OF ANAL FISTULA
46280	6	REMOVAL OF ANAL FISTULA
46285	2	REMOVAL OF ANAL FISTULA
46288 ¹⁹	6	REPAIR ANAL FISTULA
CPT SUBSECTION: ENDOSCOPY		
46608	2	ANOSCOPY/REMOVE FOR BODY
46610	2	ANOSCOPY/REMOVE LESION
46611	2	ANOSCOPY
46612	2	ANOSCOPY/REMOVE LESIONS
46615 ¹⁹	4	ANOSCOPY
CPT SUBSECTION: REPAIR		
46700	5	REPAIR OF ANAL STRICTURE
46705	5	REPAIR OF ANAL STRICTURE
46750	5	REPAIR OF ANAL SPHINCTER
46753	5	RECONSTRUCTION OF ANUS
46754	4	REMOVAL OF SUTURE FROM ANUS
46760	4	REPAIR OF ANAL SPHINCTER
46761 ¹⁹	5	REPAIR OF ANAL SPHINCTER
46762 ¹⁹	9	IMPLANT ARTIFICIAL SPHINCTER
CPT SUBSECTION: DESTRUCTION		
46917 ¹⁹	2	LASER SURGERY, ANAL LESIONS
CPT SUBSECTION: DESTRUCTION		
46922	2	EXCISION OF ANAL LESION(S)
46924	2	DESTRUCTION, ANAL LESION(S)
46937	4	CRYOTHERAPY OF RECTAL LESION
46938	4	CRYOTHERAPY OF RECTAL LESION
LIVER		
CPT SUBSECTION: INCISION		
47000	3	NEEDLE BIOPSY OF LIVER
BILIARY TRACT		
CPT SUBSECTION: INTRODUCTION		
47510	4	INSERT CATHETER, BILE DUCT
47511 ¹⁹	10	INSERT BILE DUCT DRAIN
47525	2	CHANGE BILE DUCT CATHETER
47530	2	REVISE/REINSERT BILE TUBE
CPT SUBSECTION: ENDOSCOPY		
47552	4	BILIARY ENDOSCOPY THRU SKIN
47553	5	BILIARY ENDOSCOPY THRU SKIN
47554	5	BILIARY ENDOSCOPY THRU SKIN

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
47555	5	BILIARY ENDOSCOPY THRU SKIN
47556 ¹⁹	10	BILIARY ENDOSCOPY THRU SKIN
CPT SUBSECTION: LAPAROSCOPY		
47560 ¹³	5	LAPAROSCOPY W/CHOLANGIO
47561 ¹³	5	LAPARO W/CHOLANGIO/BIOPSY
CPT SUBSECTION: EXCISION		
47630	5	REMOVE BILE DUCT STONE
PANCREAS		
CPT SUBSECTION: EXCISION		
48102	2	NEEDLE BIOPSY, PANCREAS
ABDOMEN, PERITONEUM, AND OMENTUM		
CPT SUBSECTION: INCISION		
49000 ²⁰	6	EXPLORATION OF ABDOMEN
49080	2	PUNCTURE, PERITONEAL CAVITY
49081	4	REMOVAL OF ABDOMINAL FLUID
49085	4	REMOVE ABDOMEN FOREIGN BODY
CPT SUBSECTION: EXCISION AND DESTRUCTION		
49180	2	BIOPSY, ABDOMINAL MASS
49250 ²	6	EXCISION OF UMBILICUS
CPT SUBSECTION: LAPAROSCOPY		
49320 ¹³	6	DIAG LAPARO SEPARATE PROC
49321 ¹³	7	LAPAROSCOPY, BIOPSY
49322 ¹³	6	LAPAROSCOPY, ASPIRATION
CPT SUBSECTION: INTRODUCTION AND REVISION		
49400 ²⁰	2	AIR INJECTION INTO ABDOMEN
49420	2	INSERT ABDOMINAL DRAIN
49421	2	INSERT ABDOMINAL DRAIN
49422 ¹⁹	2	REMOVE PERM CANNULA/CATHETER
49425 ²⁰	4	INSERT ABDOMEN-VENOUS DRAIN
49426	4	REVISE ABDOMEN-VENOUS SHUNT
CPT SUBSECTION: HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY		
49495 ¹⁹	6	RPR ING HERNIA BABY, REDUC
49496 ¹⁹	6	RPR ING HERNIA BABY, BLOCKED
49500	7	RPR ING HERNIA, INIT, REDUCE
49501 ¹⁹	10	RPR ING HERNIA, INIT BLOCKED
49505	7	RPR I/HERN INIT REDUC > 5 YR
49507 ¹⁹	10	RPR I/HERN INIT BLOCK > 5 YR
49520	8	REREPAIR ING HERNIA, REDUCE
49521 ¹⁹	10	REREPAIR ING HERNIA, BLOCKED
49525	6	REPAIR ING HERNIA, SLIDING
49540	4	REPAIR LUMBAR HERNIA
49550	7	RPR FEM HERNIA, INIT, REDUCE
49553 ¹⁹	10	RPR FEM HERNIA, INIT BLOCKED
49555	7	REREPAIR FEM HERNIA, REDUCE

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CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
49557 ¹⁹	10	REREPAIR FEM HERNIA, BLOCKED
49560	9	RPR VENTRAL HERN INIT, REDUC
49561 ¹⁹	10	RPR VENTRAL HERN INIT, BLOCK
49565	6	REREPAIR VENTRL HERN, REDUCE
49566 ¹⁹	10	REREPAIR VENTRL HERN, BLOCK
49568 ¹⁹	9	HERNIA REPAIR W/MESH
49570	6	RPR EPIGASTRIC HERN, REDUCE
49572 ¹⁹	10	RPR EPIGASTRIC HERN, BLOCK
49580	7	RPR UMBIL HERN, REDUC < 5 YR
49582 ¹⁹	10	RPR UMBIL HERN, BLOCK < 5 YR
49585	5	RPR UMBIL HERN, REDUC > 5 YR
49587 ¹⁹	10	RPR UMBIL HERN, BLOCK > 5 YR
49590	5	REPAIR SPIGELIAN HERNIA
49600 ¹⁹	6	REPAIR UMBILICAL LESION

CPT SUBSECTION: LAPAROSCOPY

49650 ¹³	6	LAPARO HERNIA REPAIR INITIAL
49651 ¹³	9	LAPARO HERNIA REPAIR RECUR

URINARY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
KIDNEY		

CPT SUBSECTION: INCISION

50020 ²⁰	4	RENAL ABSCESS, OPEN DRAIN
50040 ²⁰	5	DRAINAGE OF KIDNEY

CPT SUBSECTION: EXCISION

50200	2	BIOPSY OF KIDNEY
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CPT SUBSECTION: INTRODUCTION

50390	2	DRAINAGE OF KIDNEY LESION
50392	2	INSERT KIDNEY DRAIN
50393	2	INSERT URETERAL TUBE
50395	2	CREATE PASSAGE TO KIDNEY
50396	2	MEASURE KIDNEY PRESSURE
50398	2	CHANGE KIDNEY TUBE

CPT SUBSECTION: SUTURE

50520 ²⁰	2	CLOSE KIDNEY-SKIN FISTULA
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CPT SUBSECTION: ENDOSCOPY

50551	2	KIDNEY ENDOSCOPY
50553	2	KIDNEY ENDOSCOPY
50555	2	KIDNEY ENDOSCOPY & BIOPSY
50557	2	KIDNEY ENDOSCOPY & TREATMENT
50559	2	RENAL ENDOSCOPY/RADIOTRACER
50561	2	KIDNEY ENDOSCOPY & TREATMENT
50570 ²⁰	2	KIDNEY ENDOSCOPY

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URINARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
50572 ²⁰	2	KIDNEY ENDOSCOPY
50574 ²⁰	2	KIDNEY ENDOSCOPY & BIOPSY
50576 ²⁰	2	KIDNEY ENDOSCOPY & TREATMENT
50578 ²⁰	2	RENAL ENDOSCOPY/RADIOTRACER
50580 ²⁰	2	KIDNEY ENDOSCOPY & TREATMENT
CPT SUBSECTION: OTHER PROCEDURES		
50590 ¹¹	11	FRAGMENTING OF KIDNEY STONE
URETER		
CPT SUBSECTION: INTRODUCTION		
50684 ²⁰	2	INJECTION FOR URETER X-RAY
50688	2	CHANGE OF URETER TUBE
50690 ²⁰	2	INJECTION FOR URETER X-RAY
CPT SUBSECTION: LAPAROSCOPY		
50947 ¹⁹	10	LAPARO NEW URETER/BLADDER
50948 ¹⁹	10	LAPARO NEW URETER/BLADDER
CPT SUBSECTION: ENDOSCOPY		
50951	2	ENDOSCOPY OF URETER
50953	2	ENDOSCOPY OF URETER
50955	2	URETER ENDOSCOPY & BIOPSY
50957	2	URETER ENDOSCOPY & TREATMENT
50959	2	URETER ENDOSCOPY & TRACER
50961	2	URETER ENDOSCOPY & TREATMENT
50970	2	URETER ENDOSCOPY
50972	2	URETER ENDOSCOPY & CATHETER
50974	2	URETER ENDOSCOPY & BIOPSY
50976	2	URETER ENDOSCOPY & TREATMENT
50978	2	URETER ENDOSCOPY & TRACER
50980	2	URETER ENDOSCOPY & TREATMENT
BLADDER		
CPT SUBSECTION: INCISION		
51005 ²⁰	2	DRAINAGE OF BLADDER
51010	2	DRAINAGE OF BLADDER
51020	6	INCISE & TREAT BLADDER
51030	6	INCISE & TREAT BLADDER
51040 ²	6	INCISE & DRAIN BLADDER
51045	6	INCISE BLADDER/DRAIN URETER
51050 ¹⁹	6	REMOVAL OF BLADDER STONE
51065 ¹⁹	6	REMOVE URETER CALCULUS
51080 ¹⁹	2	DRAINAGE OF BLADDER ABSCESS
CPT SUBSECTION: EXCISION		
51500	6	REMOVAL OF BLADDER CYST
51520 ¹⁹	6	REMOVAL OF BLADDER LESION
CPT SUBSECTION: INTRODUCTION		
51600 ²⁰	1	INJECTION FOR BLADDER X-RAY

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URINARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
51605 ²⁰	2	PREPARATION FOR BLADDER XRAY
51610 ²⁰	2	INJECTION FOR BLADDER X-RAY
51710	2	CHANGE OF BLADDER TUBE
51715 ¹⁹	5	ENDOSCOPIC INJECTION/IMPLANT
CPT SUBSECTION: URODYNAMICS		
51725 ²⁰	2	SIMPLE CYSTOMETROGRAM
51726	1	COMPLEX CYSTOMETROGRAM
51772	2	URETHRA PRESSURE PROFILE
51785	2	ANAL/URINARY MUSCLE STUDY
51865 ²⁰	6	REPAIR OF BLADDER WOUND
51880	2	REPAIR OF BLADDER OPENING
51900 ²⁰	6	REPAIR BLADDER/VAGINA LESION
51920 ²⁰	5	CLOSE BLADDER-UTERUS FISTULA
CPT SUBSECTION: ENDOSCOPY-SYSTOSCOPY, URETHROSCOPY, CYSTOURETHROSCOPY		
52000	2	CYSTOSCOPY
52001 ¹⁶	4	CYSTOSCOPY, REMOVAL OF CLOTS
52005	5	CYSTOSCOPY & URETER CATHETER
52007	4	CYSTOSCOPY AND BIOPSY
52010	4	CYSTOSCOPY & DUCT CATHETER
CPT SUBSECTION: TRANSURETHRAL SURGERY (URETHRA AND BLADDER)		
52204	5	CYSTOSCOPY
52214	4	CYSTOSCOPY AND TREATMENT
52224	4	CYSTOSCOPY AND TREATMENT
52234	6	CYSTOSCOPY AND TREATMENT
52235	6	CYSTOSCOPY AND TREATMENT
52240	5	CYSTOSCOPY AND TREATMENT
52250	6	CYSTOSCOPY AND RADIOTRACER
52260	5	CYSTOSCOPY AND TREATMENT
52270	4	CYSTOSCOPY & REVISE URETHRA
52275	4	CYSTOSCOPY & REVISE URETHRA
52276	5	CYSTOSCOPY AND TREATMENT
52277	4	CYSTOSCOPY AND TREATMENT
52281	4	CYSTOSCOPY AND TREATMENT
52282 ¹⁹	10	CYSTOSCOPY, IMPLANT STENT
52283	4	CYSTOSCOPY AND TREATMENT
52285	6	CYSTOSCOPY AND TREATMENT
52290	4	CYSTOSCOPY AND TREATMENT
52300	4	CYSTOSCOPY AND TREATMENT
52305	4	CYSTOSCOPY AND TREATMENT
52310	4	CYSTOSCOPY AND TREATMENT
52315	4	CYSTOSCOPY AND TREATMENT
52317	2	REMOVE BLADDER STONE
52318	4	REMOVE BLADDER STONE
CPT SUBSECTION: TRANSURETHRAL SURGERY (URETER AND PELVIS)		
52320	7	CYSTOSCOPY AND TREATMENT

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URINARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
52325	6	CYSTOSCOPY, STONE REMOVAL
52327 ¹⁹	4	CYSTOSCOPY, INJECT MATERIAL
52330	4	CYSTOSCOPY AND TREATMENT
52332	6	CYSTOSCOPY AND TREATMENT
52334	5	CREATE PASSAGE TO KIDNEY
52335 ¹⁴	5	ENDOSCOPY OF URINARY TRACT
52336 ¹⁴	6	CYSTOSCOPY, STONE REMOVAL
52337 ¹⁴	6	CYSTOSCOPY, STONE REMOVAL
52338 ¹⁴	6	CYSTOSCOPY AND TREATMENT
52340 ¹⁴	5	CYSTOSCOPY AND TREATMENT
52341 ¹⁹	5	CYSTO W/URETER STRICTURE TX
52342 ¹⁹	5	CYSTO W/UP STRICTURE TX
52343 ¹⁹	5	CYSTO W/RENAL STRICTURE TX
52344 ¹⁹	5	CYSTO/URETERO, STONE REMOVE
52345 ¹⁹	5	CYSTO/URETERO W/UP STRICTURE
52346 ¹⁹	5	CYSTOURETERO W/RENAL STRICT
52351 ¹⁵	5	CYSTOURETRO & OR PYELOSCOPE
52352 ¹⁵	6	CYSTOURETRO W/STONE REMOVE
52353 ¹⁵	6	CYSTOURETERO W/LITHOTRIPSY
52354 ¹⁵	6	CYSTOURETRO & OR PYELOSCOPE
52355 ¹⁹	6	CYSTOURETERO W/EXCISE TUMOR

CPT SUBSECTION: TRANSURETHRAL SURGERY (VESICAL NECK AND PROSTATE)

52400 ¹⁵	5	CYSTOURETERO W/CONGEN REPR
52450 ²	5	INCISION OF PROSTATE
52500	5	REVISION OF BLADDER NECK
52510 ¹⁹	5	DILATION PROSTATIC URETHRA
52601	6	PROSTATECTOMY (TURP)
52606	2	CONTROL POSTOP BLEEDING
52612	4	PROSTATECTOMY, FIRST STAGE
52614	2	PROSTATECTOMY, SECOND STAGE
52620	2	REMOVE RESIDUAL PROSTATE
52630	4	REMOVE PROSTATE REGROWTH
52640	4	RELIEVE BLADDER CONTRACTURE
52647 ¹⁹	10	LASER SURGERY OF PROSTATE
52648 ¹⁹	10	LASER SURGERY OF PROSTATE
52650 ³	4	TRANSURETHRAL CRYOSURGICAL REMOVAL OF PROSTATE (POSTOPERATIVE IRRIGATIONS AND ASPIRATION OF SLOUGHING TISSUE INCLUDED)
52700	4	DRAINAGE OF PROSTATE ABSCESS

URETHRA

CPT SUBSECTION: INCISION

53000	2	INCISION OF URETHRA
53010	2	INCISION OF URETHRA
53020	1	INCISION OF URETHRA
53040	4	DRAINAGE OF URETHRA ABSCESS
53080 ¹⁹	5	DRAINAGE OF URINARY LEAKAGE

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URINARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: EXCISION		
53200	2	BIOPSY OF URETHRA
53210	7	REMOVAL OF URETHRA
53215	7	REMOVAL OF URETHRA
53220	4	TREATMENT OF URETHRA LESION
53230	4	REMOVAL OF URETHRA LESION
53235	5	REMOVAL OF URETHRA LESION
53240	4	SURGERY FOR URETHRA POUCH
53250	4	REMOVAL OF URETHRA GLAND
53260	4	TREATMENT OF URETHRA LESION
53265	4	TREATMENT OF URETHRA LESION
53270 ¹⁹	4	REMOVAL OF URETHRA GLAND
53275	4	REMOVAL OF URETHRA GLAND
CPT SUBSECTION: REPAIR		
53400	5	REVISE URETHRA, STAGE 1
53405	4	REVISE URETHRA, STAGE 2
53410	4	RECONSTRUCTION OF URETHRA
53420	5	RECONSTRUCT URETHRA, STAGE 1
53425	4	RECONSTRUCT URETHRA, STAGE 2
53430	4	RECONSTRUCTION OF URETHRA
53431 ¹⁶	4	RECONSTRUCT URETHRA/BLADDER
53440	4	CORRECT BLADDER FUNCTION
53442	2	REMOVE PERINEAL PROSTHESIS
53444 ¹⁶	4	INSERT TANDEM CUFF
53445 ¹⁶	2	INSERT URO/VES NCK SPHINCTER
53446 ¹⁶	2	REMOVE URO SPHINCTER
53447	2	REMOVE/REPLACE UR SPHINCTER
53449	2	REPAIR URO SPHINCTER
53450	2	REVISION OF URETHRA
53460	2	REVISION OF URETHRA
CPT SUBSECTION: SUTURE		
53502	4	REPAIR OF URETHRA INJURY
53505	4	REPAIR OF URETHRA INJURY
53510	4	REPAIR OF URETHRA INJURY
53515	4	REPAIR OF URETHRA INJURY
53520	4	REPAIR OF URETHRA DEFECT
CPT SUBSECTION: MANIPULATION		
53605	4	DILATE URETHRA STRICTURE
53665	2	DILATION OF URETHRA
CPT SUBSECTION: OTHER PROCEDURES		
53850 ¹⁹	10	PROSTATIC MICROWAVE THERMOTX

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MALE GENITAL SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
PENIS		
CPT SUBSECTION: INCISION		
54000	4	SLITTING OF PREPUCE
54001	4	SLITTING OF PREPUCE
54015 ²	6	DRAIN PENIS LESION
CPT SUBSECTION: DESTRUCTION		
54057	2	LASER SURG, PENIS LESION(S)
54060	2	EXCISION OF PENIS LESION(S)
54065	2	DESTRUCTION, PENIS LESION(S)
CPT SUBSECTION: EXCISION		
54100	2	BIOPSY OF PENIS
54105	2	BIOPSY OF PENIS
54110	4	TREATMENT OF PENIS LESION
54111 ¹⁹	4	TREAT PENIS LESION, GRAFT
54112 ¹⁹	4	TREAT PENIS LESION, GRAFT
54115	2	TREATMENT OF PENIS LESION
54120	4	PARTIAL REMOVAL OF PENIS
54125 ²⁰	4	REMOVAL OF PENIS
54150	1	CIRCUMCISION
54152	2	CIRCUMCISION
54160	2	CIRCUMCISION
54161	4	CIRCUMCISION
54162 ¹⁶	4	LYSIS PENIL CIRCUMCIS LESION
54163 ¹⁶	4	REPAIR OF CIRCUMCISION
54164 ¹⁶	4	FRENULOTOMY OF PENIS
CPT SUBSECTION: INTRODUCTION		
54205 ²	6	TREATMENT OF PENIS LESION
54220	2	TREATMENT OF PENIS LESION
CPT SUBSECTION: REPAIR		
54300	5	REVISION OF PENIS
54304 ¹⁹	5	REVISION OF PENIS
54308 ¹⁹	5	RECONSTRUCTION OF URETHRA
54312 ¹⁹	5	RECONSTRUCTION OF URETHRA
54316 ¹⁹	5	RECONSTRUCTION OF URETHRA
54318 ¹⁹	5	RECONSTRUCTION OF URETHRA
54322 ¹⁹	5	RECONSTRUCTION OF URETHRA
54324 ¹⁹	5	RECONSTRUCTION OF URETHRA
54326 ¹⁹	5	RECONSTRUCTION OF URETHRA
54328 ¹⁹	5	REVISE PENIS/URETHRA
54340 ¹⁹	5	SECONDARY URETHRAL SURGERY
54344 ¹⁹	5	SECONDARY URETHRAL SURGERY
54348 ¹⁹	5	SECONDARY URETHRAL SURGERY
54352 ¹⁹	5	RECONSTRUCT URETHRA/PENIS
54360	5	PENIS PLASTIC SURGERY

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MALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
54380 ¹⁹	5	REPAIR PENIS
54385 ¹⁹	5	REPAIR PENIS
54400 ¹⁹	5	INSERT SEMI-RIGID PROSTHESIS
54401 ¹⁹	5	INSERT SEMI-RIGID PROSTHESIS
54405 ¹⁹	5	INSERT MULTI-COMP PENIS PROS
54406 ¹⁹	5	REMOVE MULTI-COMP PENIS PROSTH
54408 ¹⁹	5	REPAIR MULTI-COMP PENIS PROS
54410 ¹⁹	5	REMOVE/REPLACE PENIS PROSTH
54415 ¹⁹	5	REMOVE SELF-CONTD PENIS PROS
54416 ¹⁹	5	REMV/REPL PENIS CONTAIN PROS
54420	6	REVISION OF PENIS
54435	6	REVISION OF PENIS
54440	6	REPAIR OF PENIS
CPT SUBSECTION: MANIPULATION		
54450	2	PREPUTIAL STRETCHING
TESTIS		
CPT SUBSECTION: EXCISION		
54500	2	BIOPSY OF TESTIS
54505	2	BIOPSY OF TESTIS
54510 ¹⁷	4	REMOVAL OF TESTIS LESION
54512 ¹⁶	4	EXCISE LESION TESTIS
54520	7	REMOVAL OF TESTIS
54522 ¹⁹	5	ORCHIECTOMY, PARTIAL
54530	6	REMOVAL OF TESTIS
54550	6	EXPLORATION FOR TESTIS
CPT SUBSECTION: REPAIR		
54600	6	REDUCE TESTIS TORSION
54620	5	SUSPENSION OF TESTIS
54640	6	SUSPENSION OF TESTIS
54660	4	REVISION OF TESTIS
54670	5	REPAIR TESTIS INJURY
54680	5	RELOCATION OF TESTIS(ES)
CPT SUBSECTION: LAPAROSCOPY		
54690 ¹⁹	10	LAPAROSCOPY, ORCHIECTOMY
EPIDIDYMIS		
CPT SUBSECTION: INCISION		
54700	4	DRAINAGE OF SCROTUM
CPT SUBSECTION: EXCISION		
54800	2	BIOPSY OF EPIDIDYMIS
54820	2	EXPLORATION OF EPIDIDYMIS
54830	5	REMOVE EPIDIDYMIS LESION
54840	6	REMOVE EPIDIDYMIS LESION
54860	5	REMOVAL OF EPIDIDYMIS
54861	6	REMOVAL OF EPIDIDYMIS

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MALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: REPAIR		
54900	6	FUSION OF SPERMATIC DUCTS
54901	6	FUSION OF SPERMATIC DUCTS
TUNICA VAGINALIS		
CPT SUBSECTION: EXCISION		
55040	6	REMOVAL OF HYDROCELE
55041	7	REMOVAL OF HYDROCELES
CPT SUBSECTION: REPAIR		
55060	6	REPAIR OF HYDROCELE
SCROTUM		
CPT SUBSECTION: INCISION		
55100	2	DRAINAGE OF SCROTUM ABSCESS
55110	4	EXPLORE SCROTUM
55120	4	REMOVAL OF SCROTUM LESION
CPT SUBSECTION: EXCISION		
55150	2	REMOVAL OF SCROTUM
CPT SUBSECTION: REPAIR		
55175	2	REVISION OF SCROTUM
55180	4	REVISION OF SCROTUM
VAS DEFERENS		
CPT SUBSECTION: INCISION		
55200	4	INCISION OF SPERM DUCT
CPT SUBSECTION: EXCISION		
55250 ¹⁹	4	REMOVAL OF SPERM DUCT(S)
CPT SUBSECTION: REPAIR		
55400	2	REPAIR OF SPERM DUCT
SPERMATIC CORD		
CPT SUBSECTION: EXCISION		
55500	5	REMOVAL OF HYDROCELE
55520	6	REMOVAL OF SPERM CORD LESION
55530	6	REVISE SPERMATIC CORD VEINS
55535	6	REVISE SPERMATIC CORD VEINS
55540	7	REVISE HERNIA & SPERM VEINS
CPT SUBSECTION: LAPAROSCOPY		
55550 ¹⁹	10	LAPARO LIGATE SPERMATIC VEIN
SEMINAL VESICLES		
CPT SUBSECTION: INCISION		
55600 ²⁰	2	INCISE SPERM DUCT POUCH
55605 ²⁰	2	INCISE SPERM DUCT POUCH
CPT SUBSECTION: EXCISION		
55650 ²⁰	2	REMOVE SPERM DUCT POUCH
55680	2	REMOVE SPERM POUCH LESION

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MALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
PROSTATE		
CPT SUBSECTION: INCISION		
55700	3	BIOPSY OF PROSTATE
55705	4	BIOPSY OF PROSTATE
55720	2	DRAINAGE OF PROSTATE ABSCESS
55725 ¹⁹	4	DRAINAGE OF PROSTATE ABSCESS
CPT SUBSECTION: EXCISION		
55859 ¹⁹	10	PERCUT/NEEDLE INSERT, PROS

FEMALE GENITAL SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: ENDOSCOPY - LAPAROSCOPY - HYSTEROSCOPY		
56300 ¹²	6	LAPAROSCOPY; DIAGNOSTIC
56301 ¹²	7	LAPAROSCOPY; TUBAL CAUTERY
56302 ¹²	8	LAPAROSCOPY; TUBAL BLOCK
56303 ¹²	9	LAPAROSCOPY; EXCISE LESIONS
56304 ¹²	10	LAPAROSCOPY; LYSIS
56305 ¹²	7	LAPAROSCOPY; BIOPSY
56306 ¹²	6	LAPAROSCOPY; ASPIRATION
56307 ¹²	10	LAPAROSCOPY; REMOVE ADNEXA
56309 ¹²	6	LAPAROSCOPY; REMOVE MYOMA
56309 ^{5, 12}	7	LAPAROSCOPY; REMOVE MYOMA
56316 ^{2, 12}	6	LAPAROSCOPIC HERNIA REPAIR
56317 ^{2, 12}	9	LAPAROSCOPIC HERNIA REPAIR
56343 ^{8, 12}	7	LAPAROSCOPIC SALPINGOSTOMY
56344 ^{8, 12}	7	LAPAROSCOPIC FIMBRIOPLASTY
56350 ¹²	6	HYSTEROSCOPY; DIAGNOSTIC
56351 ¹²	2	HYSTEROSCOPY; BIOPSY
56351 ^{5, 12}	5	HYSTEROSCOPY; BIOPSY
56352 ¹²	4	HYSTEROSCOPY; LYSIS
56353 ¹²	4	HYSTEROSCOPY; RESECT SEPTUM
56354 ¹²	5	HYSTEROSCOPY; REMOVE MYOMA
56355 ¹²	2	HYSTEROSCOPY; REMOVE IMPACT
56356 ¹²	9	HYSTEROSCOPY; ABLATION
56360 ¹⁰	4	PERITONEOSCOPY; WITHOUT BIOPSY
56361 ¹⁰	5	PERITONEOSCOPY; WITH BIOPSY
56362 ¹²	5	LAPAROSCOPY W/CHOLANGIO
56363 ¹²	5	LAPAROSCOPY W/BIOPSY
VULVA, PERINEUM, AND INTROITUS		
CPT SUBSECTION: INCISION		
56405 ²⁰	4	I & D OF VULVA/PERINEUM
56440	5	SURGERY FOR VULVA LESION
56441 ²	2	LYSIS OF LABIAL LESION(S)

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FEMALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: DESTRUCTION		
56515	6	DESTROY VULVA LESION/S COMPL
CPT SUBSECTION: EXCISION		
56605 ²⁰	4	BIOPSY OF VULVA/PERINEUM
56620	6	PARTIAL REMOVAL OF VULVA
56625	9	COMPLETE REMOVAL OF VULVA
56700	2	PARTIAL REMOVAL OF HYMEN
56720	2	INCISION OF HYMEN
56740	7	REMOVE VAGINA GLAND LESION
CPT SUBSECTION: REPAIR		
56800	5	REPAIR OF VAGINA
56810	7	REPAIR OF PERINEUM
VAGINA		
CPT SUBSECTION: INCISION		
57000	2	EXPLORATION OF VAGINA
57010	4	DRAINAGE OF PELVIC ABSCESS
57020	4	DRAINAGE OF PELVIC FLUID
57023 ¹⁹	2	I & D VAG HEMATOMA, NON-OB
CPT SUBSECTION: DESTRUCTION		
57065	6	DESTROY VAG LESIONS, COMPLEX
CPT SUBSECTION: EXCISION		
57105	4	BIOPSY OF VAGINA
57130	4	REMOVE VAGINA LESION
57135	4	REMOVE VAGINA LESION
CPT SUBSECTION: INTRODUCTION		
57180	2	TREAT VAGINAL BLEEDING
CPT SUBSECTION: REPAIR		
57200	2	REPAIR OF VAGINA
57210	4	REPAIR VAGINA/PERINEUM
57220	5	REVISION OF URETHRA
57230	5	REPAIR OF URETHRAL LESION
57240	7	REPAIR BLADDER & VAGINA
57250	7	REPAIR RECTUM & VAGINA
57260	7	REPAIR OF VAGINA
57265	9	EXTENSIVE REPAIR OF VAGINA
57268	5	REPAIR OF BOWEL BULGE
57289 ¹⁹	7	REPAIR BLADDER AND VAGINA
57291 ¹⁹	7	CONSTRUCTION OF VAGINA
57300	5	REPAIR RECTUM-VAGINA FISTULA
57310 ²⁰	5	REPAIR URETHROVAGINAL LESION
57311 ²⁰	6	REPAIR URETHROVAGINAL LESION
57320 ²⁰	5	REPAIR BLADDER-VAGINA LESION

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FEMALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: MANIPULATION		
57400	4	DILATION OF VAGINA
57410	3	PELVIC EXAMINATION
57415 ¹⁹	4	REMOVE VAGINAL FOREIGN BODY
CERVIX UTERI		
CPT SUBSECTION: EXCISION		
57513	6	LASER SURGERY OF CERVIX
57520	7	CONIZATION OF CERVIX
57522 ¹	4	CONIZATION OF CERVIX
57530	5	REMOVAL OF CERVIX
57550	5	REMOVAL OF RESIDUAL CERVIX
57556 ¹⁹	7	REMOVE CERVIX, REPAIR BOWEL
CPT SUBSECTION: REPAIR		
57700	2	REVISION OF CERVIX
57720	5	REVISION OF CERVIX
CPT SUBSECTION: MANIPULATION		
57800 ²⁰	2	DILATION OF CERVICAL CANAL
57820	5	D & C OF RESIDUAL CERVIX
CORPUS UTERI		
CPT SUBSECTION: EXCISION		
58120	5	DILATION AND CURETTAGE
58145	7	REMOVAL OF UTERUS LESION
CPT SUBSECTION: INTRODUCTION		
58350 ¹⁹	5	REOPEN FALLOPIAN TUBE
58353 ¹⁵	6	ENDOMETR ABLATE, THERMAL
CPT SUBSECTION: LAPAROSCOPY		
58545 ¹⁹	10	LAPAROSCOPIC MYOMECTOMY
58546 ¹⁹	10	LAPARO-MYOMECTOMY, COMPLEX
58550 ¹⁹	10	LAPARO-ASST VAG HYSTERECTOMY
58551 ^{13, 20}	7	LAPAROSCOPY, REMOVE MYOMA
58555 ¹³	6	HYSTEROSCOPY, DX, SEP PROC
58558 ¹³	5	HYSTEROSCOPY, BIOPSY
58559 ¹³	4	HYSTEROSCOPY, LYSIS
58560 ^{13, 21}	5	HYSTEROSCOPY, RESECT SEPTUM
58561 ¹³	5	HYSTEROSCOPY, REMOVE MYOMA
58562 ^{13, 21}	5	HYSTEROSCOPY, REMOVE FB
58563 ¹³	9	HYSTEROSCOPY, ABLATION
OVIDUCT		
CPT SUBSECTION: INCISION		
58600	7	DIVISION OF FALLOPIAN TUBE
58615	8	OCCLUDE FALLOPIAN TUBE(S)
CPT SUBSECTION: LAPAROSCOPY		
58660 ¹³	10	LAPAROSCOPY, LYSIS
58661 ¹³	10	LAPAROSCOPY, REMOVE ADNEXA

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FEMALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
58662 ¹³	9	LAPAROSCOPY, EXCISE LESIONS
58670 ¹³	7	LAPAROSCOPY, TUBAL CAUTERY
58671 ¹³	8	LAPAROSCOPY, TUBAL BLOCK
58672 ¹³	7	LAPAROSCOPY, FIMBRIOPLASTY
58673 ¹³	7	LAPAROSCOPY, SALPINGOSTOMY
OVARY		
CPT SUBSECTION: INCISION		
58800	5	DRAINAGE OF OVARIAN CYST(S)
58820	5	DRAIN OVARY ABSCESS, OPEN
CPT SUBSECTION: EXCISION		
58900	5	BIOPSY OF OVARY(S)
DELIVERY, ANTEPARTUM, AND POSTPARTUM CARE		
CPT SUBSECTION: EXCISION		
59160 ¹⁹	5	D & C AFTER DELIVERY
CPT SUBSECTION: REPAIR		
59320 ¹⁹	2	REVISION OF CERVIX
CPT SUBSECTION: VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE		
59414	1	DELIVER PLACENTA
CPT SUBSECTION: ABORTION		
59812	5	TREATMENT OF MISCARRIAGE
59820	3	CARE OF MISCARRIAGE
59821	5	TREATMENT OF MISCARRIAGE
59840	1	ABORTION
59841	1	ABORTION
CPT SUBSECTION: OTHER PROCEDURES		
59870 ¹⁹	7	EVACUATE M OLE OF UTERUS
59871 ¹⁹	7	REMOVE CERCLAGE SUTURE

ENDOCRINE SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
THYROID GLAND		
CPT SUBSECTION: INCISION		
60000	2	DRAIN THYROID/TONGUE CYST
CPT SUBSECTION: EXCISION		
60200	4	REMOVE THYROID LESION
60220 ²⁰	4	PARTIAL REMOVAL OF THYROID
60225 ²⁰	5	PARTIAL REMOVAL OF THYROID
60280	6	REMOVE THYROID DUCT LESION
60281	6	REMOVE THYROID DUCT LESION

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NERVOUS SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
SKULL, MENINGES, AND BRAIN		
CPT SUBSECTION: PUNCTURE FOR INJECTION, DRAINAGE, OR ASPIRATION		
61020	2	REMOVE BRAIN CAVITY FLUID
61026	2	INJECTION INTO BRAIN CANAL
61050	2	REMOVE BRAIN CANAL FLUID
61055	2	INJECTION INTO BRAIN CANAL
61070	2	BRAIN CANAL SHUNT PROCEDURE
CPT SUBSECTION: TWIST DRILL, BURR HOLE(S) OR TREPHINE		
61215	5	INSERT BRAIN-FLUID DEVICE
CPT SUBSECTION: STEREOTAXIS		
61790	5	TREAT TRIGEMINAL NERVE
61791	5	TREAT TRIGEMINAL TRACT
CPT SUBSECTION: NEUROSTIMULATORS, INTRACRANIAL		
61885	4	IMPLANT NEUROSTIM ONE ARRAY
61886 ¹⁹	5	IMPLANT NEUROSTIM ARRAYS
61888	2	REVISE/REMOVE NEURORECEIVER
CPT SUBSECTION: CSF SHUNT		
62194	2	REPLACE/IRRIGATE CATHETER
62225	2	REPLACE/IRRIGATE CATHETER
62230	4	REPLACE/REVISE BRAIN SHUNT
62256 ²⁰	4	REMOVE BRAIN CAVITY SHUNT
62263 ^{13, 18}	2	LYSIS EPIDURAL ADHESIONS
SPINE AND SPINAL CORD		
CPT SUBSECTION: PUNCTURE FOR INJECTION, DRAINAGE, OR ASPIRATION		
62268	2	DRAIN SPINAL CORD CYST
62269	2	NEEDLE BIOPSY, SPINAL CORD
62270	1	SPINAL FLUID TAP, DIAGNOSTIC
62272	2	DRAIN CEREBRO SPINAL FLUID
62273	2	TREAT EPIDURAL SPINE LESION
62274 ¹²	2	INJECT SPINAL ANESTHETIC
62275 ^{2, 12}	2	INJECT SPINAL ANESTHETIC
62276 ¹²	2	INJECT SPINAL ANESTHETIC
62277 ¹²	2	INJECT SPINAL ANESTHETIC
62278 ¹²	1	INJECT SPINAL ANESTHETIC
62279 ¹²	2	INJECT SPINAL ANESTHETIC
62280	2	TREAT SPINAL CORD LESION
62281 ¹⁹	2	TREAT SPINAL CORD LESION
62282	2	TREAT SPINAL CANAL LESION
62887 ¹⁹	10	PERCUTANEOUS DISKECTOMY
62288 ¹²	2	INJECTION INTO SPINAL CANAL
62289 ¹²	1	INJECTION INTO SPINAL CANAL
62294	5	INJECTION INTO SPINAL ARTERY
62310 ¹³	2	INJECT SPINE C/T
62311 ¹³	2	INJECT SPINE L/S (CD)

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NERVOUS SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
62318 ¹³	2	INJECT SPINE W/CATH, C/T
62319 ¹³	2	INJECT SPINE W/CATH L/S (CD)
CPT SUBSECTION: CATHETER IMPLANTATION		
62350 ⁸	4	IMPLANT SPINAL CANAL CATH
62351 ^{8, 20}	4	IMPLANT SPINAL CANAL CATH
62355 ¹⁹	4	REMOVE SPINAL CANAL CATHETER
CPT SUBSECTION: RESERVOIR/PUMP IMPLANTATION		
62360 ⁸	4	INSERT SPINE INFUSION DEVICE
62361 ⁸	4	IMPLANT SPINE INFUSION PUMP
62362 ⁸	4	IMPLANT SPINE INFUSION PUMP
62365 ⁸	4	REMOVE SPINE INFUSION DEVICE
62367 ^{8, 20}	4	ANALYZE SPINE INFUSION PUMP
62368 ^{8, 20}	4	ANALYZE SPINE INFUSION PUMP
CPT SUBSECTION: STEREOTAXIS		
63600	4	REMOVE SPINAL CORD LESION
63610	2	STIMULATION OF SPINAL CORD
CPT SUBSECTION: NEUROSTIMULATORS, SPINAL		
63650	4	IMPLANT NEUROELECTRODES
63660	2	REVISE/REMOVE NEUROELECTRODE
63685	4	IMPLANT NEURORECEIVER
63688	2	REVISE/REMOVE NEURORECEIVER
CPT SUBSECTION: SHUNT, SPINAL CSF		
63744	5	REVISION OF SPINAL SHUNT
63746	4	REMOVAL OF SPINAL SHUNT
63750 ⁷	6	INSERTION, SUBARACHNOID CATHETER WITH RESERVOIR AND/OR PUMP FOR INTERMITTENT OR CONTINUOUS INFUSION OF DRUG, INCLUDING LAMINECTOMY
63780 ⁷	4	INSERTION OR REPLACEMENT, SUBARACHNOID OR EPIDURAL CATHETER, WITH RESERVOIR AND/OR PUMP FOR DRUG INFUSION, WITHOUT LAMINECTOMY

**EXTRACRANIAL NERVES, PERIPHERAL NERVES,
AND AUTONOMIC NERVOUS SYSTEM**

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC		
CPT SUBSECTION: SOMATIC NERVES		
64410	2	INJECTION FOR NERVE BLOCK
64415	2	INJECTION FOR NERVE BLOCK
64417	2	INJECTION FOR NERVE BLOCK
64420	2	INJECTION FOR NERVE BLOCK
64421	2	INJECTION FOR NERVE BLOCK
64430	2	INJECTION FOR NERVE BLOCK

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**EXTRACRANIAL NERVES, PERIPHERAL NERVES,
AND AUTONOMIC NERVOUS SYSTEM (CONTINUED)**

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
64442 ¹²	1	INJECTION FOR NERVE BLOCK
64443 ¹²	2	INJECTION FOR NERVE BLOCK
64470 ¹³	3	INJ PARAVERTEBRAL C/T
64470 ^{13, 18}	2	INJ PARAVERTEBRAL C/T
64472 ¹³	3	INJ PARAVERTEBRAL C/T ADD-ON
64472 ^{13, 18}	2	INJ PARAVERTEBRAL C/T ADD-ON
64475 ¹³	1	INJ PARAVERTEBRAL L/S
64476 ¹³	2	INJ PARAVERTEBRAL L/S ADD-ON
64479 ¹³	3	INJ FORAMEN EPIDURAL C/T
64479 ^{13, 18}	2	INJ FORAMEN EPIDURAL C/T
64480 ¹³	3	INJ FORAMEN EPIDURAL ADD-ON
64480 ^{13, 18}	2	INJ FORAMEN EPIDURAL ADD-ON
64483 ¹³	3	INJ FORAMEN EPIDURAL L/S
64483 ^{13, 18}	2	INJ FORAMEN EPIDURAL L/S
64484 ¹³	3	INJ FORAMEN EPIDURAL ADD-ON
64484 ^{13, 18}	2	INJ FORAMEN EPIDURAL ADD-ON
CPT SUBSECTION: SYMPATHETIC NERVES		
64510	2	INJECTION FOR NERVE BLOCK
64520	2	INJECTION FOR NERVE BLOCK
64530	2	INJECTION FOR NERVE BLOCK
CPT SUBSECTION: NEUROSTIMULATORS, PERIPHERAL NERVE		
64553 ¹⁹	2	IMPLANT NEUROELECTRODES
64573 ¹⁹	2	IMPLANT NEUROELECTRODES
64575	2	IMPLANT NEUROELECTRODES
64577 ¹⁹	2	IMPLANT NEUROELECTRODES
64580 ¹⁹	2	IMPLANT NEUROELECTRODES
64585 ¹⁹	2	REVISE/REMOVE NEUROELECTRODE
64590	4	IMPLANT NEURORECEIVER
64595	2	REVISE/REMOVE NEURORECEIVER
DESTRUCTION BY NEUROLYTIC AGENT (E.G., CHEMICAL, THERMAL, ELECTRICAL, RADIOFREQUENCY)		
CPT SUBSECTION: SOMATIC NERVES		
64600	2	INJECTION TREATMENT OF NERVE
64605	2	INJECTION TREATMENT OF NERVE
64610	2	INJECTION TREATMENT OF NERVE
64620	2	INJECTION TREATMENT OF NERVE
64622	2	DESTR PARAVERTEBRAL NERVE L/S
64623	2	DESTR PARAVERTEBRAL N ADD-ON
64626 ¹³	3	DESTR PARAVERTEBRAL NERVE C/T
64626 ^{13, 18}	2	DESTR PARAVERTEBRAL NERVE C/T
64627 ¹³	3	DESTR PARAVERTEBRAL N ADD-ON
64627 ^{13, 18}	2	DESTR PARAVERTEBRAL N ADD-ON
64630	4	INJECTION TREATMENT OF NERVE
CPT SUBSECTION: SYMPATHETIC NERVES		
64680	4	INJECTION TREATMENT OF NERVE

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EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: NEUROLOPLASTY (EXPLANATION, NEUROLYSIS OR NERVE DEOMPRESSION)		
64702	2	REVISE FINGER/TOE NERVE
64704	2	REVISE HAND/FOOT NERVE
64708	4	REVISE ARM/LEG NERVE
64712	4	REVISION OF SCIATIC NERVE
64713	4	REVISION OF ARM NERVE(S)
64714	4	REVISE LOW BACK NERVE(S)
64716	5	REVISION OF CRANIAL NERVE
64718	9	REVISE ULNAR NERVE AT ELBOW
64719	4	REVISE ULNAR NERVE AT WRIST
64721	5	CARPAL TUNNEL SURGERY
64722	2	RELIEVE PRESSURE ON NERVE(S)
64726	2	RELEASE FOOT/TOE NERVE
64727	2	INTERNAL NERVE REVISION
CPT SUBSECTION: TRANSECTION OR AVULSION OF NERVE		
64732	4	INCISION OF BROW NERVE
64734	4	INCISION OF CHEEK NERVE
64736	4	INCISION OF CHIN NERVE
64738	4	INCISION OF JAW NERVE
64740	4	INCISION OF TONGUE NERVE
64742	4	INCISION OF FACIAL NERVE
64744	4	INCISE NERVE, BACK OF HEAD
64746	4	INCISE DIAPHRAGM NERVE
64771	4	SEVER CRANIAL NERVE
64772	4	INCISION OF SPINAL NERVE
CPT SUBSECTION: EXCISION-SOMATIC NERVES		
64774	4	REMOVE SKIN NERVE LESION
64776	5	REMOVE DIGIT NERVE LESION
64778	4	DIGIT NERVE SURGERY ADD-ON
64782	5	REMOVE LIMB NERVE LESION
64783	4	LIMB NERVE SURGERY ADD-ON
64784	5	REMOVE NERVE LESION
64786	5	REMOVE SCIATIC NERVE LESION
64787	4	IMPLANT NERVE END
64788	5	REMOVE SKIN NERVE LESION
64790	5	REMOVAL OF NERVE LESION
64792	5	REMOVAL OF NERVE LESION
64795	4	BIOPSY OF NERVE
CPT SUBSECTION: EXCISION-SYMPATHETIC NERVES		
64802	4	REMOVE SYMPATHETIC NERVES
64821 ¹⁹	6	REMOVE SYMPATHETIC NERVES
CPT SUBSECTION: NERVE REPAIR BY SUTURE (NEURORRHAPHY)		
64830	7	MICROREPAIR OF NERVE
64831	6	REPAIR OF DIGIT NERVE

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AND AUTONOMIC NERVOUS SYSTEM (CONTINUED)**

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
64832	2	REPAIR NERVE ADD-ON
64834	4	REPAIR OF HAND OR FOOT NERVE
64835	5	REPAIR OF HAND OR FOOT NERVE
64836	5	REPAIR OF HAND OR FOOT NERVE
64837	2	REPAIR NERVE ADD-ON
64840	4	REPAIR OF LEG NERVE
64856	4	REPAIR/TRANSPOSE NERVE
64857	4	REPAIR ARM/LEG NERVE
64858	4	REPAIR SCIATIC NERVE
64859	2	NERVE SURGERY
64861	5	REPAIR OF ARM NERVES
64862	5	REPAIR OF LOW BACK NERVES
64864	5	REPAIR OF FACIAL NERVE
64865	6	REPAIR OF FACIAL NERVE
64870	6	FUSION OF FACIAL/OTHER NERVE
64872	4	SUBSEQUENT REPAIR OF NERVE
64874	5	REPAIR & REVISE NERVE ADD-ON
64876	5	REPAIR NERVE/SHORTEN BONE

CPT SUBSECTION: NEURORRHAPHY WITH NERVE GRAFT

64885 ¹⁹	4	NERVE GRAFT, HEAD OR NECK
64886 ¹⁹	4	NERVE GRAFT, HEAD OR NECK
64890	4	NERVE GRAFT, HAND OR FOOT
64891	4	NERVE GRAFT, HAND OR FOOT
64892	4	NERVE GRAFT, ARM OR LEG
64893	4	NERVE GRAFT, ARM OR LEG
64895	5	NERVE GRAFT, HAND OR FOOT
64896	5	NERVE GRAFT, HAND OR FOOT
64897	5	NERVE GRAFT, ARM OR LEG
64898	5	NERVE GRAFT, ARM OR LEG
64901	4	NERVE GRAFT ADD-ON
64902	4	NERVE GRAFT ADD-ON
64905	4	NERVE PEDICLE TRANSFER
64907	2	NERVE PEDICLE TRANSFER

EYE AND OCULAR ADNEXA

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
EYEBALL		

CPT SUBSECTION: REMOVAL OF EYE

65091	5	REVISE EYE
65093	5	REVISE EYE WITH IMPLANT
65101	5	REMOVAL OF EYE
65103	5	REMOVE EYE/INSERT IMPLANT

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
65105	6	REMOVE EYE/ATTACH IMPLANT
65110	7	REMOVAL OF EYE
65112	9	REMOVE EYE/REVISE SOCKET
65114	9	REMOVE EYE/REVISE SOCKET
CPT SUBSECTION: SECONDARY IMPLANT PROCEDURES		
65130	5	INSERT OCULAR IMPLANT
65135	4	INSERT OCULAR IMPLANT
65140	5	ATTACH OCULAR IMPLANT
65150	4	REVISE OCULAR IMPLANT
65155	5	REINSERT OCULAR IMPLANT
65175	2	REMOVAL OF OCULAR IMPLANT
CPT SUBSECTION: REMOVAL OF OCULAR FOREIGN BODY		
65235	4	REMOVE FOREIGN BODY FROM EYE
65260	5	REMOVE FOREIGN BODY FROM EYE
65265	6	REMOVE FOREIGN BODY FROM EYE
65270	4	REPAIR OF EYE WOUND
65272	4	REPAIR OF EYE WOUND
65275	6	REPAIR OF EYE WOUND
65280	6	REPAIR OF EYE WOUND
65285	6	REPAIR OF EYE WOUND
65290	5	REPAIR OF EYE SOCKET WOUND
ANTERIOR SEGMENT - CORNEA		
CPT SUBSECTION: EXCISION		
65400	2	REMOVAL OF EYE LESION
65410	4	BIOPSY OF CORNEA
65420	4	REMOVAL OF EYE LESION
65426	7	REMOVAL OF EYE LESION
CPT SUBSECTION: KERATOPLASTY		
65710	9	CORNEAL TRANSPLANT
65730	9	CORNEAL TRANSPLANT
65750	9	CORNEAL TRANSPLANT
65755	9	CORNEAL TRANSPLANT
CPT SUBSECTION: OTHER PROCEDURES		
65770 ²	9	REVISE CORNEA WITH IMPLANT
65772 ¹⁹	6	CORRECTION OF ASTIGMATISM
65772 ¹⁹	6	CORRECTION OF ASTIGMATISM
ANTERIOR SEGMENT - ANTERIOR CHAMBER		
CPT SUBSECTION: INCISION		
65800	2	DRAINAGE OF EYE
65805	2	DRAINAGE OF EYE
65810	5	DRAINAGE OF EYE
65815	4	DRAINAGE OF EYE
65850	6	INCISION OF EYE

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: OTHER PROCEDURES		
65865	2	INCISE INNER EYE ADHESIONS
65870	6	INCISE INNER EYE ADHESIONS
65875	6	INCISE INNER EYE ADHESIONS
65880	6	INCISE INNER EYE ADHESIONS
65900	7	REMOVE EYE LESION
65920	9	REMOVE IMPLANT OF EYE
65930	7	REMOVE BLOOD CLOT FROM EYE
66020	2	INJECTION TREATMENT OF EYE
66030	2	INJECTION TREATMENT OF EYE
ANTERIOR SEGMENT - ANTERIOR SCLERA		
CPT SUBSECTION: EXCISION		
66130	9	REMOVE EYE LESION
66150	6	GLAUCOMA SURGERY
66155	6	GLAUCOMA SURGERY
66160	4	GLAUCOMA SURGERY
66165	6	GLAUCOMA SURGERY
66170	8	GLAUCOMA SURGERY
66172	6	INCISION OF EYE
66180 ²	7	IMPLANT EYE SHUNT
66185 ²	4	REVISE EYE SHUNT
CPT SUBSECTION: REPAIR		
66220	5	REPAIR EYE LESION
66225	6	REPAIR/GRAFT EYE LESION
CPT SUBSECTION: REVISION OPERATIVE WOUND		
66250	4	FOLLOW-UP SURGERY OF EYE
ANTERIOR SEGMENT - IRIS, CILIARY BODY		
CPT SUBSECTION: IRIDOTOMY, IRIDECTOMY		
66500	2	INCISION OF IRIS
66505	2	INCISION OF IRIS
66600	5	REMOVE IRIS AND LESION
66605	5	REMOVAL OF IRIS
66625	5	REMOVAL OF IRIS
66630	5	REMOVAL OF IRIS
66635	5	REMOVAL OF IRIS
CPT SUBSECTION: REPAIR		
66680	5	REPAIR IRIS & CILIARY BODY
66682	4	REPAIR IRIS & CILIARY BODY
CPT SUBSECTION: DESTRUCTION		
66700	4	DESTRUCTION, CILIARY BODY
66710	4	DESTRUCTION, CILIARY BODY
66720	4	DESTRUCTION, CILIARY BODY
66740	4	DESTRUCTION, CILIARY BODY
66762 ⁴	2	REVISION OF IRIS

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
ANTERIOR SEGMENT - LENS		
CPT SUBSECTION: INCISION		
66821	2	AFTER CATARACT LASER SURGERY
66825 ¹⁹	6	REPOSITION INTRAOCULAR LENS
CPT SUBSECTION: REMOVAL CATARACT		
66830	6	REMOVAL OF LENS LESION
66840	6	REMOVAL OF LENS MATERIAL
66850	9	REMOVAL OF LENS MATERIAL
66852	6	REMOVAL OF LENS MATERIAL
66920	6	EXTRACTION OF LENS
66930	7	EXTRACTION OF LENS
66940	7	EXTRACTION OF LENS
66982 ¹⁵	9	CATARACT SURGERY, COMPLEX
66983	9	CATARACT SURG W/IOL, 1 STAGE
66984	9	CATARACT SURG W/IOL, I STAGE
66985	8	INSERT LENS PROSTHESIS
66986	8	EXCHANGE LENS PROSTHESIS
CPT SUBSECTION: POSTERIOR SEGMENT - VITREOUS		
67005	6	PARTIAL REMOVAL OF EYE FLUID
67010	6	PARTIAL REMOVAL OF EYE FLUID
67015	2	RELEASE OF EYE FLUID
67025	2	REPLACE EYE FLUID
67027 ¹⁹	6	IMPLANT EYE DRUG SYSTEM
67030	2	INCISE INNER EYE STRANDS
67031	4	LASER SURGERY, EYE STRANDS
67036	10	REMOVAL OF INNER EYE FLUID
67038	7	STRIP RETINAL MEMBRANE
67039	9	LASER TREATMENT OF RETINA
67040	9	LASER TREATMENT OF RETINA
POSTERIOR SEGMENT - RETINAL DETACHMENT		
CPT SUBSECTION: REPAIR		
67101 ⁴	6	REPAIR DETACHED RETINA
67105 ⁴	7	REPAIR DETACHED RETINA
67107	10	REPAIR DETACHED RETINA
67108	9	REPAIR DETACHED RETINA
67109 ⁷	7	REPAIR OF RETINAL DETACHMENT, ONE OR MORE SESSIONS; BY TECHNIQUE OTHER THAN 67101-67108 AND 67110
67112	9	REREPAIR DETACHED RETINA
67115	4	RELEASE ENCIRCLING MATERIAL
67120	4	REMOVE EYE IMPLANT MATERIAL
67121	4	REMOVE EYE IMPLANT MATERIAL
CPT SUBSECTION: PROPHYLAXIS		
67141	4	TREATMENT OF RETINA

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
POSTERIOR SEGMENT - OTHER PROCEDURES		
CPT SUBSECTION: DESTRUCTION - RETINA, CHOROID		
67208 ⁴	2	TREATMENT OF RETINAL LESION
67218	7	TREATMENT OF RETINAL LESION
67227	2	TREATMENT OF RETINAL LESION
CPT SUBSECTION: SCLERAL REPAIR		
67250	5	REINFORCE EYE WALL
67255	5	REINFORCE/GRAFT EYE WALL
CPT SUBSECTION: OCULARY ADNEXA - EXTRAOCULAR MUSCLES		
67311	5	REVISE EYE MUSCLE
67312	6	REVISE TWO EYE MUSCLES
67314	6	REVISE EYE MUSCLE
67316	6	REVISE TWO EYE MUSCLES
67318	6	REVISE EYE MUSCLE(S)
67320	6	REVISE EYE MUSCLE(S) ADD-ON
67331	6	EYE SURGERY FOLLOW-UP ADD-ON
67332	6	REREVISE EYE MUSCLES ADD-ON
67334 ¹⁹	6	REVISE EYE MUSCLE W/SUTURE
67335 ¹⁹	6	EYE SUTURE DURING SURGERY
67340 ²	6	REVISE EYE MUSCLE ADD-ON
CPT SUBSECTION: OTHER PROCEDURES		
67350	2	BIOPSY EYE MUSCLE
OCULAR ADNEXA - ORBIT		
CPT SUBSECTION: EXPLORATION, EXCISION, DECOMPRESSION		
67400	5	EXPLORE/BIOPSY EYE SOCKET
67405	6	EXPLORE/DRAIN EYE SOCKET
67412	7	EXPLORE/TREAT EYE SOCKET
67413	7	EXPLORE/TREAT EYE SOCKET
67415	2	ASPIRATION, ORBITAL CONTENTS
67420	7	EXPLORE/TREAT EYE SOCKET
67430	7	EXPLORE/TREAT EYE SOCKET
67440	7	EXPLORE/DRAIN EYE SOCKET
67450	7	EXPLORE/BIOPSY EYE SOCKET
CPT SUBSECTION: OTHER PROCEDURES		
67550	6	INSERT EYE SOCKET IMPLANT
67560	4	REVISE EYE SOCKET IMPLANT
OCULAR ADNEXA - EYELIDS		
CPT SUBSECTION: INCISION		
67715	2	INCISION OF EYELID FOLD
CPT SUBSECTION: EXCISION OR REMOVAL OF LESION INVOLVING MORE THAN SKIN (I.E., INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA)		
67808	4	REMOVE EYELID LESION(S)
67830	4	REVISE EYELASHES
67835	4	REVISE EYELASHES

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
CPT SUBSECTION: TARSORRHAPHY		
67880	5	REVISION OF EYELID
67882	5	REVISION OF EYELID
CPT SUBSECTION: REPAIR OF BROW/PTOSIS BLEPHAROPTOSIS, LID RETRACTION		
67900 ¹⁹	6	REPAIR BROW DEFECT
67901	7	REPAIR BROW DEFECT
67902	7	REPAIR EYELID DEFECT
67903	6	REPAIR EYELID DEFECT
67904	6	REPAIR EYELID DEFECT
67906	7	REPAIR EYELID DEFECT
67908	6	REPAIR EYELID DEFECT
67909	6	REVISE EYELID DEFECT
67911	5	REVISE EYELID DEFECT
CPT SUBSECTION: REPAIR ECTROPION, ENTROPION		
67914	5	REPAIR EYELID DEFECT
67916	6	REPAIR EYELID DEFECT
67917	6	REPAIR EYELID DEFECT
67921	5	REPAIR EYELID DEFECT
67923	6	REPAIR EYELID DEFECT
67924	6	REPAIR EYELID DEFECT
CPT SUBSECTION: RECONSTRUCTIVE SURGERY, BLEPHAROPLASTY INVOLVING MORE THAN SKIN (I.E., INVOLVING LID MARGIN, TARSUS, AND/OR PALPERBRAL CONJUNCTIVA)		
67935	4	REPAIR EYELID WOUND
67950	4	REVISION OF EYELID
67961	5	REVISION OF EYELID
67966	5	REVISION OF EYELID
67971	5	RECONSTRUCTION OF EYELID
67973	5	RECONSTRUCTION OF EYELID
67974	5	RECONSTRUCTION OF EYELID
67975	5	RECONSTRUCTION OF EYELID
OCULAR ADNEXA - CONJUNCTIVA		
CPT SUBSECTION: EXCISION, DESTRUCTION		
68115 ¹⁹	4	REMOVE EYELID LINING LESION
68130	4	REMOVE EYELID LINING LESION
CPT SUBSECTION: CONJUNCTIVOPLASTY		
68320	6	REVISE/GRAFT EYELID LINING
68325	6	REVISE/GRAFT EYELID LINING
68326	6	REVISE/GRAFT EYELID LINING
68328	6	REVISE/GRAFT EYELID LINING
68330	6	REVISE EYELID LINING
68335	6	REVISE/GRAFT EYELID LINING
68340	6	SEPARATE EYELID ADHESIONS
CPT SUBSECTION: OTHER PROCEDURES		
68360	4	REVISE EYELID LINING

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
68362	4	REVISE EYELID LINING
OCULAR ADNEXA - LACRIMAL SYSTEM		
CPT SUBSECTION: EXCISION		
68500	5	REMOVAL OF TEAR GLAND
68505	5	PARTIAL REMOVAL, TEAR GLAND
68510	2	BIOPSY OF TEAR GLAND
68520	5	REMOVAL OF TEAR SAC
68525	2	BIOPSY OF TEAR SAC
68540	5	REMOVE TEAR GLAND LESION
68550	5	REMOVE TEAR GLAND LESION
CPT SUBSECTION: REPAIR		
68700	4	REPAIR TEAR DUCTS
68720	6	CREATE TEAR SAC DRAIN
68745	6	CREATE TEAR DUCT DRAIN
68750	6	CREATE TEAR DUCT DRAIN
68770 ¹⁹	6	CLOSE TEAR SYSTEM FISTULA
CPT SUBSECTION: PROBING AND RELATED PROCEDURES		
68810 ⁹	2	PROBE NASOLACRIMAL DUCT
68811 ⁹	3	PROBE NASOLACRIMAL DUCT
68815 ⁹	3	PROBE NASOLACRIMAL DUCT
68825 ¹⁰	3	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION, UNILATERAL OR BILATERAL; REQUIRING GENERAL ANESTHESIA

AUDITORY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
EXTERNAL EAR		
CPT SUBSECTION: EXCISION		
69110	2	REMOVE EXTERNAL EAR, PARTIAL
69120	4	REMOVAL OF EXTERNAL EAR
69140	4	REMOVE EAR CANAL LESION(S)
69145	4	REMOVE EAR CANAL LESION(S)
69150	5	EXTENSIVE EAR CANAL SURGERY
CPT SUBSECTION: REMOVAL OF FOREIGN BODY		
69205	3	CLEAR OUTER EAR CANAL
CPT SUBSECTION: REPAIR		
69300 ¹⁹	5	REVISE EXTERNAL EAR
69310	5	REBUILD OUTER EAR CANAL
69320	9	REBUILD OUTER EAR CANAL
MIDDLE EAR		
CPT SUBSECTION: INCISION		
69421	3	INCISION OF EARDRUM

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AUDITORY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
69424 ²⁰	1	REMOVE VENTILATING TUBE
69436	3	CREATE EARDRUM OPENING
69440	5	EXPLORATION OF MIDDLE EAR
69450	2	EARDRUM REVISION
CPT SUBSECTION: EXCISION		
69501	9	MASTOIDECTOMY
69502	9	MASTOIDECTOMY
69505	9	REMOVE MASTOID STRUCTURES
69511	9	EXTENSIVE MASTOID SURGERY
69530	9	EXTENSIVE MASTOID SURGERY
69550	7	REMOVE EAR LESION
69552	9	REMOVE EAR LESION
CPT SUBSECTION: REPAIR		
69601	9	MASTOID SURGERY REVISION
69602	9	MASTOID SURGERY REVISION
69603	9	MASTOID SURGERY REVISION
69604	9	MASTOID SURGERY REVISION
69605	9	MASTOID SURGERY REVISION
69620	7	REPAIR OF EARDRUM
69631	8	REPAIR EARDRUM STRUCTURES
69632	7	REBUILD EARDRUM STRUCTURES
69633	7	REBUILD EARDRUM STRUCTURES
69635	9	REPAIR EARDRUM STRUCTURES
69636	9	REBUILD EARDRUM STRUCTURES
69637	9	REBUILD EARDRUM STRUCTURES
69641	9	REVISE MIDDLE EAR & MASTOID
69642	9	REVISE MIDDLE EAR & MASTOID
69643	9	REVISE MIDDLE EAR & MASTOID
69644	9	REVISE MIDDLE EAR & MASTOID
69645	9	REVISE MIDDLE EAR & MASTOID
69646	9	REVISE MIDDLE EAR & MASTOID
69650	9	RELEASE MIDDLE EAR BONE
69660	7	REVISE MIDDLE EAR BONE
69661	7	REVISE MIDDLE EAR BONE
69662	7	REVISE MIDDLE EAR BONE
69666	6	REPAIR MIDDLE EAR STRUCTURES
69667	6	REPAIR MIDDLE EAR STRUCTURES
69670	5	REMOVE MASTOID AIR CELLS
69676	5	REMOVE MIDDLE EAR NERVE
CPT SUBSECTION: OTHER PROCEDURES		
69700	5	CLOSE MASTOID FISTULA
69710 ²⁰	5	IMPLANT/REPLACE HEARING AID
69711	2	REMOVE/REPAIR HEARING AID
69714 ¹⁹	10	IMPLANT TEMPLE BONE W/STIMUL
69715 ¹⁹	10	TEMPLE BNE IMPLNT W/STIMULAT

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AUDITORY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION**
69717 ¹⁹	10	TEMPLE BONE IMPLANT REVISION
69718 ¹⁹	10	REVISE TEMPLE BONE IMPLANT
69720	7	RELEASE FACIAL NERVE
69725	7	RELEASE FACIAL NERVE
69740	7	REPAIR FACIAL NERVE
69745	7	REPAIR FACIAL NERVE

INNER EAR

CPT SUBSECTION: INCISION, DESTRUCTION

69801	7	INCISE INNER EAR
69802	9	INCISE INNER EAR
69805	9	EXPLORE INNER EAR
69806	9	EXPLORE INNER EAR
69820	7	ESTABLISH INNER EAR WINDOW
69840	7	REVISE INNER EAR WINDOW

CPT SUBSECTION: EXCISION

69905	9	REMOVE INNER EAR
69910	9	REMOVE INNER EAR & MASTOID
69915	9	INCISE INNER EAR NERVE

CPT SUBSECTION: INSERTION

69930	9	IMPLANT COCHLEAR DEVICE
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HCPCS CODE	TRICARE PAYMENT GROUP*	SHORT DESCRIPTION
G0260 ¹⁹	2	INJ FOR SACROILLIAC JT ANESTH

Except as provided below, all procedures are effective as of November 1, 1994

- 1 Code added for services performed on or after January 1, 1995
- 2 Code added for services performed on or after February 27, 1995
- 3 Code deleted for services performed on or after April 1, 1995
- 4 Code deleted for services performed on or after April 26, 1995
- 5 Payment group changed for services performed on or after February 27, 1995
- 6 Code added October 1995 effective for services performed on or after November 1, 1994
- 7 Code deleted for services performed on or after March 31, 1996
- 8 Code added for services performed on or after January 1, 1996
- 9 Code added for services performed on or after January 1, 1997
- 10 Code deleted for services performed on or after January 1, 1997
- 11 Code added for services performed on or after November 1, 1998
- 12 Code deleted for services performed on or after January 1, 2000
- 13 Code added for services performed on or after January 1, 2000
- 14 Code deleted for services performed on or after January 1, 2001
- 15 Code added for services performed on or after January 1, 2001
- 16 Code added for services performed on or after January 1, 2002
- 17 Code deleted for services performed on or after January 1, 2002
- 18 Payment group changed for services performed on or after November 1, 2000

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- ¹⁹ Code added for services performed on or after July 1, 2003
- ²⁰ Code deleted for services performed on or after July 1, 2003
- ²¹ Payment group changed for services performed on or after July 1, 2003

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TRICARE-APPROVED AMBULATORY SURGERY PROCEDURES ON OR AFTER 11/01/2003

The following CPT codes, TRICARE payment groups, and short descriptions are valid for claims on or after November 1, 2003. See [Chapter 9, Addendum A](#) for claims occurring on or before October 31, 2003.

INTEGUMENTARY SYSTEM

CPT CODE	TRICARE	
	PAYMENT GROUP	SHORT DESCRIPTION*
SKIN, SUBCUTANEOUS AND AREOLAR TISSUES		
CPT SUBSECTION: INCISION		
10121	4	REMOVE FOREIGN BODY
10180	4	COMPLEX DRAINAGE, WOUND
CPT SUBSECTION: EXCISION DEBRIDEMENT		
11010	4	DEBRIDE SKIN, FX
11011	4	DEBRIDE SKIN/MUSCLE, FX
11012	4	DEBRIDE SKIN/MUSCLE/BONE, FX
11042	1	DEBRIDE SKIN/TISSUE
11043	4	DEBRIDE TISSUE/MUSCLE
11044	4	DEBRIDE TISSUE/MUSCLE/BONE
CPT SUBSECTION: EXCISION-BENIGN LESIONS		
11404	4	EXC TR-EXT B9+MARG 3.1-4 CM
11406	6	EXC TR-EXT B9+MARG > 4.0 CM
11424	4	EXC H-F-NK-SP B9+MARG 3.1-4
11426	4	EXC H-F-NK-SP B9+MARG > 4 CM
11444	2	EXC FACE-MM B9+MARG 3.1-4 CM
11446	4	EXC FACE-MM B9+MARG > 4 CM
11450	4	REMOVAL, SWEAT GLAND LESION
11451	4	REMOVAL, SWEAT GLAND LESION
11462	4	REMOVAL, SWEAT GLAND LESION
11463	4	REMOVAL, SWEAT GLAND LESION
11470	4	REMOVAL, SWEAT GLAND LESION
11471	4	REMOVAL, SWEAT GLAND LESION
CPT SUBSECTION: EXCISION-MALIGNANT LESIONS		
11604	4	EXC TR-EXT MLG+MARG 3.1-4 CM
11606	4	EXC TR-EXT MLG+MARG > 4 CM
11624	4	EXC H-F-NK-SP MLG+MARG 3.1-4
11626	4	EXC H-F-NK-SP MLG+MAR > 4 CM
11644	4	EXC FACE-MM MALIG+MARG 3.1-4
11646	4	EXC FACE-MM MLG+MARG > 4 CM

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INTEGUMENTARY SYSTEM (CONTINUED)

CPT CODE	TRICARE	
	PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: MISCELLANEOUS		
11770	6	REMOVAL OF PILONIDAL LESION
11771	6	REMOVAL OF PILONIDAL LESION
11772	6	REMOVAL OF PILONIDAL LESION
CPT SUBSECTION: INTRODUCTION		
11960	4	INSERT TISSUE EXPANDER(S)
11970	5	REPLACE TISSUE EXPANDER
11971	2	REMOVE TISSUE EXPANDER(S)
CPT SUBSECTION: REPAIR-SIMPLE		
12005	4	REPAIR SUPERFICIAL WOUND(S)
12006	4	REPAIR SUPERFICIAL WOUND(S)
12007	4	REPAIR SUPERFICIAL WOUND(S)
12016	4	REPAIR SUPERFICIAL WOUND(S)
12017	4	REPAIR SUPERFICIAL WOUND(S)
12018	4	REPAIR SUPERFICIAL WOUND(S)
12020	2	CLOSURE OF SPLIT WOUND
12021	2	CLOSURE OF SPLIT WOUND
CPT SUBSECTION: REPAIR-INTERMEDIATE		
12034	4	LAYER CLOSURE OF WOUND(S)
12035	4	LAYER CLOSURE OF WOUND(S)
12036	4	LAYER CLOSURE OF WOUND(S)
12037	4	LAYER CLOSURE OF WOUND(S)
12044	4	LAYER CLOSURE OF WOUND(S)
12045	4	LAYER CLOSURE OF WOUND(S)
12046	4	LAYER CLOSURE OF WOUND(S)
12047	4	LAYER CLOSURE OF WOUND(S)
12054	4	LAYER CLOSURE OF WOUND(S)
12055	4	LAYER CLOSURE OF WOUND(S)
12056	4	LAYER CLOSURE OF WOUND(S)
12057	4	LAYER CLOSURE OF WOUND(S)
CPT SUBSECTION: REPAIR-COMPLEX		
13100	4	REPAIR OF WOUND OR LESION
13101	5	REPAIR OF WOUND OR LESION
13102 ⁷	2	REPAIR WOUND/LESION ADD-ON
13120	4	REPAIR OF WOUND OR LESION
13121	5	REPAIR OF WOUND OR LESION
13122 ⁷	2	REPAIR WOUND/LESION ADD-ON
13131	4	REPAIR OF WOUND OR LESION
13132	5	REPAIR OF WOUND OR LESION
13133 ⁷	2	REPAIR WOUND/LESION ADD-ON
13150	5	REPAIR OF WOUND OR LESION
13151	5	REPAIR OF WOUND OR LESION
13152	5	REPAIR OF WOUND OR LESION
13153 ⁷	5	REPAIR WOUND/LESION ADD-ON
13160	4	LATE CLOSURE OF WOUND

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INTEGUMENTARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: ADJACENT TISSUE TRANSFER OR REARRANGEMENT		
14000	4	SKIN TISSUE REARRANGEMENT
14001	5	SKIN TISSUE REARRANGEMENT
14020	5	SKIN TISSUE REARRANGEMENT
14021	5	SKIN TISSUE REARRANGEMENT
14040	6	SKIN TISSUE REARRANGEMENT
14041	5	SKIN TISSUE REARRANGEMENT
14060	6	SKIN TISSUE REARRANGEMENT
14061	5	SKIN TISSUE REARRANGEMENT
14300	6	SKIN TISSUE REARRANGEMENT
14350	5	SKIN TISSUE REARRANGEMENT
CPT SUBSECTION: FREE SKIN GRAFTS		
15000 ⁸	4	SKIN GRAFT
15001 ^{3, 8}	2	SKIN GRAFT ADD-ON
15002 ⁷	4	WND PREP, CH/INF, TRK/ARM/LG
15003 ⁷	2	WND PREP, CH/INF ADDL 100 CM
15004 ⁷	4	WND PREP CH/INF, F/N/HF/G
15005 ⁷	2	WND PREP, F/N/HF/G, ADDL CM
15040 ⁵	4	HARVEST CULTURED SKIN GRAFT
15050	4	SKIN PINCH GRAFT
15100	4	SKIN SPLIT GRAFT
15101	5	SKIN SPLIT GRAFT ADD-ON
15110 ⁵	4	EPIDRM AUTOGRFT TRNK/ARM/LEG
15111 ⁵	2	EPIDRM AUTOGRFT T/A/L ADD-ON
15115 ⁵	4	EPIDRM A-GRFT FACE/NCK/HF/G
15116 ⁵	2	EPIDRM A-GRFT F/N/HF/G ADDL
15120	4	SKIN SPLIT GRAFT
15121	5	SKIN SPLIT GRAFT ADD-ON
15130 ⁵	4	DERM AUTOGRAFT, TRNK/ARM/LEG
15131 ⁵	2	DERM AUTOGRAFT T/A/L ADD-ON
15135 ⁵	4	DERM AUTOGRAFT FACE/NCK/HF/G
15136 ⁵	2	DERM AUTOGRAFT, F/N/HF/G ADD
15150 ⁵	4	CULT EPIDERM GRFT T/ARM/LEG
15151 ⁵	2	CULT EPIDERM GRFT T/A/L ADDL
15152 ⁵	2	CULT EPIDERM GRAFT T/A/L +%
15155 ⁵	4	CULT EPIDERM GRAFT, F/N/HF/G
15156 ⁵	2	CULT EPIDRM GRFT F/N/HFG ADD
15157 ⁵	2	CULT EPIDERM GRFT F/N/HFG +%
15200	5	SKIN FULL GRAFT
15201	4	SKIN FULL GRAFT ADD-ON
15220	4	SKIN FULL GRAFT
15221	4	SKIN FULL GRAFT ADD-ON
15240	5	SKIN FULL GRAFT
15241	5	SKIN FULL GRAFT ADD-ON
15260	4	SKIN FULL GRAFT
15261	4	SKIN FULL GRAFT ADD-ON
15300 ⁵	4	APPLY SKINALLOGRFT, T/ARM/LG

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INTEGUMENTARY SYSTEM (CONTINUED)

CPT CODE	TRICARE	
	PAYMENT GROUP	SHORT DESCRIPTION*
15301 ⁵	2	APPLY SKNALLOGRFT T/A/L ADDL
15320 ⁵	4	APPLY SKIN ALLOGRFT F/N/HF/G
15321 ⁵	2	APLY SKNALLOGRFT F/N/HFG ADD
15330 ⁵	2	APLY ACELL ALOGRFT T/ARM/LEG
15331 ⁵	2	APLY ACELL GRFT T/A/L ADD-ON
15335 ⁵	4	APPLY ACELL GRAFT, F/N/HF/G
15336 ⁵	2	APLY ACELL GRFT F/N/HF/G ADD
15350 ⁶	4	SKIN HOMOGRAFT
15351 ⁶	4	SKIN HOMOGRAFT ADD-ON
15570	5	FORM SKIN PEDICLE FLAP
15572	5	FORM SKIN PEDICLE FLAP
15574	5	FORM SKIN PEDICLE FLAP
15576	5	FORM SKIN PEDICLE FLAP
15600	5	SKIN GRAFT
15610	5	SKIN GRAFT
15620	6	SKIN GRAFT
CPT SUBSECTION: PEDICLE FLAPS (SKIN AND DEEP TISSUES)		
15630	5	SKIN GRAFT
15650	7	TRANSFER SKIN PEDICLE FLAP
CPT SUBSECTION: FLAPS (SKIN AND/OR DEEP TISSUES)		
15731 ⁷	5	FOREHEAD FLAP W/VASC PEDICLE
15732	5	MUSCLE-SKIN GRAFT, HEAD/NECK
15734	5	MUSCLE-SKIN GRAFT, TRUNK
15736	5	MUSCLE-SKIN GRAFT, ARM
15738	5	MUSCLE-SKIN GRAFT, LEG
CPT SUBSECTION: OTHER GRAFTS		
15740	4	ISLAND PEDICLE FLAP GRAFT
15750	4	NEUROVASCULAR PEDICLE GRAFT
15760	4	COMPOSITE SKIN GRAFT
15770	5	DERMA-FAT-FASCIA GRAFT
CPT SUBSECTION: MISCELLANEOUS PROCEDURES		
15820	5	REVISION OF LOWER EYELID
15821	5	REVISION OF LOWER EYELID
15822	5	REVISION OF UPPER EYELID
15823	7	REVISION OF UPPER EYELID
15825	5	REMOVAL OF NECK WRINKLES
15826	5	REMOVAL OF BROW WRINKLES
15828	5	REMOVAL OF FACE WRINKLES
15829	7	REMOVAL OF SKIN WRINKLES
15830 ⁷	5	EXC SKIN ABD
15831 ⁸	5	EXCISE EXCESSIVE SKIN TISSUE
15832	5	EXCISE EXCESSIVE SKIN TISSUE
15833	5	EXCISE EXCESSIVE SKIN TISSUE
15834	5	EXCISE EXCESSIVE SKIN TISSUE
15835	5	EXCISE EXCESSIVE SKIN TISSUE
15836 ³	5	EXCISE EXCESSIVE SKIN TISSUE
15839 ³	5	EXCISE EXCESSIVE SKIN TISSUE

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INTEGUMENTARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
15840	6	GRAFT FOR FACE NERVE PALSY
15841	6	GRAFT FOR FACE NERVE PALSY
15845	6	SKIN AND MUSCLE REPAIR, FACE
15847 ⁷	5	EXC SKIN ABD ADD-ON
15876	5	SUCTION ASSISTED LIPECTOMY
15877	5	SUCTION ASSISTED LIPECTOMY
15878	5	SUCTION ASSISTED LIPECTOMY
15879	5	SUCTION ASSISTED LIPECTOMY
CPT SUBSECTION: PRESSURE ULCERS (DECUBITUS ULCERS)		
15920	5	REMOVAL OF TAIL BONE ULCER
15922	6	REMOVAL OF TAIL BONE ULCER
15931	5	REMOVE SACRUM PRESSURE SORE
15933	5	REMOVE SACRUM PRESSURE SORE
15934	5	REMOVE SACRUM PRESSURE SORE
15935	6	REMOVE SACRUM PRESSURE SORE
15936	6	REMOVE SACRUM PRESSURE SORE
15937	6	REMOVE SACRUM PRESSURE SORE
15940	5	REMOVE HIP PRESSURE SORE
15941	5	REMOVE HIP PRESSURE SORE
15944	5	REMOVE HIP PRESSURE SORE
15945	6	REMOVE HIP PRESSURE SORE
15946	6	REMOVE HIP PRESSURE SORE
15950	5	REMOVE THIGH PRESSURE SORE
15951	6	REMOVE THIGH PRESSURE SORE
15952	5	REMOVE THIGH PRESSURE SORE
15953	6	REMOVE THIGH PRESSURE SORE
15956	5	REMOVE THIGH PRESSURE SORE
15958	6	REMOVE THIGH PRESSURE SORE
CPT SUBSECTION: BURNS, LOCAL TREATMENT		
16015 ⁶	4	TREATMENT OF BURN(S)
16025 ⁵	4	DRESS/DEBRID P-THICK BURN, M
16030 ⁵	4	DRESS/DEBRID P-THICK BURN, L

BREAST

CPT SUBSECTION: INCISION

19020 4 INCISION OF BREAST LESION

CPT SUBSECTION: EXCISION

19100 1 BX BREAST PERCUT W/O IMAGE
 19101 5 BIOPSY OF BREAST, OPEN
 19102 1 BX BREAST PERCUT W/IMAGE
 19103 3 BX BREAST PERCUT W/DEVICE
 19110 4 NIPPLE EXPLORATION
 19112 5 EXCISE BREAST DUCT FISTULA
 19120 7 REMOVAL OF BREAST LESION
 19125 6 EXCISION, BREAST LESION
 19126 5 EXCISION, ADDL BREAST LESION
 19140⁸ 6 REMOVAL OF BREAST TISSUE

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INTEGUMENTARY SYSTEM (CONTINUED)

CPT CODE	TRICARE	
	PAYMENT GROUP	SHORT DESCRIPTION*
19160 ⁸	5	REMOVAL OF BREAST TISSUE
19162 ⁸	9	REMOVE BREAST TISSUE, NODES
19180 ⁸	6	REMOVAL OF BREAST
19182 ⁸	6	REMOVAL OF BREAST
CPT SUBSECTION: INTRODUCTION		
19290	2	PLACE NEEDLE WIRE, BREAST
19291	3	PLACE NEEDLE WIRE, BREAST
19295 ⁷	2	PLACE BREAST CLIP, PERCUT
19296 ³	10	PLACE PO BREAST CATH FOR RAD
19297 ⁷	10	PLACE BREAST CATH FOR RAD
19298 ³	10	PLACE BREAST RAD TUBE/CATHS
CPT SUBSECTION: REPAIR AND RECONSTRUCTION		
19300 ⁷	6	REMOVAL OF BREAST TISSUE
19301 ⁷	5	PARTIAL MASTECTOMY
19302 ⁷	9	P-MASTECTOMY W/LN REMOVAL
19303 ⁷	6	MAST, SIMPLE, COMPLETE
19304 ⁷	6	MAST, SUBQ
19316	6	SUSPENSION OF BREAST
19318	10	REDUCTION OF LARGE BREAST
19324	6	ENLARGE BREAST
19325	10	ENLARGE BREAST WITH IMPLANT
19328	2	REMOVAL OF BREAST IMPLANT
19330	2	REMOVAL OF IMPLANT MATERIAL
19340	4	IMMEDIATE BREAST PROSTHESIS
19342	5	DELAYED BREAST PROSTHESIS
19350	6	BREAST RECONSTRUCTION
19355	6	CORRECT INVERTED NIPPLE(S)
19357	7	BREAST RECONSTRUCTION
19366	7	BREAST RECONSTRUCTION
19370	6	SURGERY OF BREAST CAPSULE
19371	6	REMOVAL OF BREAST CAPSULE
19380	7	REVISE BREAST RECONSTRUCTION

MUSCULOSKELETAL SYSTEM

CPT CODE	TRICARE	
	PAYMENT GROUP	SHORT DESCRIPTION*
GENERAL		
CPT SUBSECTION: INCISION		
20005	4	INCISION OF DEEP ABSCESS
CPT SUBSECTION: EXCISION		
20200	4	MUSCLE BIOPSY
20205	5	DEEP MUSCLE BIOPSY
20206	2	NEEDLE BIOPSY, MUSCLE
20220	2	BONE BIOPSY, TROCAR/NEEDLE
20225	4	BONE BIOPSY, TROCAR/NEEDLE
20240	4	BONE BIOPSY, EXCISIONAL

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TRICARE-APPROVED AMBULATORY SURGERY PROCEDURES ON OR AFTER 11/01/2003

MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
20245	5	BONE BIOPSY, EXCISIONAL
20250	5	OPEN BONE BIOPSY
20251	5	OPEN BONE BIOPSY
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
20525	5	REMOVAL OF FOREIGN BODY
20650	5	INSERT AND REMOVE BONE PIN
20670	6	REMOVAL OF SUPPORT IMPLANT
20680	7	REMOVAL OF SUPPORT IMPLANT
20690	4	APPLY BONE FIXATION DEVICE
20692	5	APPLY BONE FIXATION DEVICE
20693	5	ADJUST BONE FIXATION DEVICE
20694	6	REMOVE BONE FIXATION DEVICE
CPT SUBSECTION: GRAFTS (OR IMPLANTS)		
20900	5	REMOVAL OF BONE FOR GRAFT
20902	6	REMOVAL OF BONE FOR GRAFT
20910	5	REMOVE CARTILAGE FOR GRAFT
20912	5	REMOVE CARTILAGE FOR GRAFT
20920	6	REMOVAL OF FASCIA FOR GRAFT
20922	5	REMOVAL OF FASCIA FOR GRAFT
20924	6	REMOVAL OF TENDON FOR GRAFT
20926	6	REMOVAL OF TISSUE FOR GRAFT
CPT SUBSECTION: MISCELLANEOUS		
20975	4	ELECTRICAL BONE STIMULATION
HEAD		
CPT SUBSECTION: INCISION		
21010	4	INCISION OF JAW JOINT
CPT SUBSECTION: EXCISION		
21015	5	RESECTION OF FACIAL TUMOR
21025	4	EXCISION OF BONE, LOWER JAW
21026	4	EXCISION OF FACIAL BONE(S)
21029	4	CONTOUR OF FACE BONE LESION
21034	5	EXCISE MAX/ZYGOMA MLG TUMOR
21040	4	EXCISE MANDIBLE LESION
21044	4	REMOVAL OF JAW BONE LESION
21046	4	REMOVE MANDIBLE CYST COMPLEX
21047	4	EXCISE LWR JAW CYST W/REPAIR
21050	5	REMOVAL OF JAW JOINT
21060	4	REMOVE JAW JOINT CARTILAGE
21070	5	REMOVE CORONOID PROCESS
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
21100	4	MAXILLOFACIAL FIXATION
CPT SUBSECTION: REPAIR, REVISION, OR RECONSTRUCTION		
21120 ³	9	RECONSTRUCTION OF CHIN
21121	9	RECONSTRUCTION OF CHIN
21122	9	RECONSTRUCTION OF CHIN

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CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
21123	9	RECONSTRUCTION OF CHIN
21125 ³	9	AUGMENTATION, LOWER JAW BONE
21127	10	AUGMENTATION, LOWER JAW BONE
21181	9	CONTOUR CRANIAL BONE LESION
21206	7	RECONSTRUCT UPPER JAW BONE
21208	9	AUGMENTATION OF FACIAL BONES
21209	7	REDUCTION OF FACIAL BONES
21210	9	FACE BONE GRAFT
21215	9	LOWER JAW BONE GRAFT
21230	9	RIB CARTILAGE GRAFT
21235	9	EAR CARTILAGE GRAFT
21240	6	RECONSTRUCTION OF JAW JOINT
21242	7	RECONSTRUCTION OF JAW JOINT
21243	7	RECONSTRUCTION OF JAW JOINT
21244	9	RECONSTRUCTION OF LOWER JAW
21245	9	RECONSTRUCTION OF JAW
21246	9	RECONSTRUCTION OF JAW
21248	9	RECONSTRUCTION OF JAW
21249	9	RECONSTRUCTION OF JAW
21267	9	REVISE EYE SOCKETS
21270	7	AUGMENTATION, CHEEK BONE
21275	9	REVISION, ORBITOFACIAL BONES
21280	7	REVISION OF EYELID
21282	7	REVISION OF EYELID
21295	2	REVISION OF JAW MUSCLE/BONE
21296	2	REVISION OF JAW MUSCLE/BONE
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
21300 ⁸	4	TREATMENT OF SKULL FRACTURE
21310	4	TREATMENT OF NOSE FRACTURE
21315	4	TREATMENT OF NOSE FRACTURE
21320	4	TREATMENT OF NOSE FRACTURE
21325	6	TREATMENT OF NOSE FRACTURE
21330	7	TREATMENT OF NOSE FRACTURE
21335	9	TREATMENT OF NOSE FRACTURE
21336	6	TREAT NASAL SEPTAL FRACTURE
21337	4	TREAT NASAL SEPTAL FRACTURE
21338	6	TREAT NASOETHMOID FRACTURE
21339	7	TREAT NASOETHMOID FRACTURE
21340	6	TREATMENT OF NOSE FRACTURE
21345	9	TREAT NOSE/JAW FRACTURE
21355	5	TREAT CHEEK BONE FRACTURE
21356 ⁷	5	TREAT CHEEK BONE FRACTURE
21400	4	TREAT EYE SOCKET FRACTURE
21401	5	TREAT EYE SOCKET FRACTURE
21421	6	TREAT MOUTH ROOF FRACTURE
21440 ⁴	5	TREAT DENTAL RIDGE FRACTURE
21445	6	TREAT DENTAL RIDGE FRACTURE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
21450	5	TREAT LOWER JAW FRACTURE
21451	6	TREAT LOWER JAW FRACTURE
21452	4	TREAT LOWER JAW FRACTURE
21453	5	TREAT LOWER JAW FRACTURE
21454	7	TREAT LOWER JAW FRACTURE
21461	6	TREAT LOWER JAW FRACTURE
21462	7	TREAT LOWER JAW FRACTURE
21465	6	TREAT LOWER JAW FRACTURE
21480	2	RESET DISLOCATED JAW
21485	4	RESET DISLOCATED JAW
21490	5	REPAIR DISLOCATED JAW
21493 ⁶	5	TREAT HYOID BONE FRACTURE
21494 ⁶	6	TREAT HYOID BONE FRACTURE
21497	4	INTERDENTAL WIRING
NECK (SOFT TISSUES) AND THORAX		
CPT SUBSECTION: INCISION		
21501	4	DRAIN NECK/CHEST LESION
21502	4	DRAIN CHEST LESION
CPT SUBSECTION: EXCISION		
21555	4	REMOVE LESION, NECK/CHEST
21556	4	REMOVE LESION, NECK/CHEST
21600	4	PARTIAL REMOVAL OF RIB
21610	4	PARTIAL REMOVAL OF RIB
CPT SUBSECTION: REPAIR, REVISION OR RECONSTRUCTION		
21700	4	REVISION OF NECK MUSCLE
21720	5	REVISION OF NECK MUSCLE
21725	5	REVISION OF NECK MUSCLE
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
21800	2	TREATMENT OF RIB FRACTURE
21805	4	TREATMENT OF RIB FRACTURE
21820	2	TREAT STERNUM FRACTURE
BACK AND FLANK		
CPT SUBSECTION: EXCISION		
21925	4	BIOPSY SOFT TISSUE OF BACK
21930	6	REMOVE LESION, BACK OR FLANK
21935	5	REMOVE TUMOR, BACK
SPINE (VERTEBRAL COLUMN)		
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
22305	2	TREAT SPINE PROCESS FRACTURE
22310	2	TREAT SPINE FRACTURE
22315	4	TREAT SPINE FRACTURE
CPT SUBSECTION: MANIPULATION		
22505	4	MANIPULATION OF SPINE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
ABDOMEN		
CPT SUBSECTION: EXCISION		
22900	6	REMOVE ABDOMINAL WALL LESION
SHOULDER		
CPT SUBSECTION: INCISION		
23000	4	REMOVAL OF CALCIUM DEPOSITS
23020	4	RELEASE SHOULDER JOINT
23030	2	DRAIN SHOULDER LESION
23031	5	DRAIN SHOULDER BURSA
23035	5	DRAIN SHOULDER BONE LESION
23040	5	EXPLORATORY SHOULDER SURGERY
23044	6	EXPLORATORY SHOULDER SURGERY
CPT SUBSECTION: EXCISION		
23066	4	BIOPSY SHOULDER TISSUES
23075	4	REMOVAL OF SHOULDER LESION
23076	4	REMOVAL OF SHOULDER LESION
23077	5	REMOVE TUMOR OF SHOULDER
23100	4	BIOPSY OF SHOULDER JOINT
23101	9	SHOULDER JOINT SURGERY
23105	6	REMOVE SHOULDER JOINT LINING
23106	6	INCISION OF COLLARBONE JOINT
23107	6	EXPLORE TREAT SHOULDER JOINT
23120	9	PARTIAL REMOVAL, COLLAR BONE
23125	7	REMOVAL OF COLLAR BONE
23130	10	REMOVE SHOULDER BONE, PART
23140	6	REMOVAL OF BONE LESION
23145	7	REMOVAL OF BONE LESION
23146	7	REMOVAL OF BONE LESION
23150	6	REMOVAL OF HUMERUS LESION
23155	7	REMOVAL OF HUMERUS LESION
23156	7	REMOVAL OF HUMERUS LESION
23170	4	REMOVE COLLAR BONE LESION
23172	4	REMOVE SHOULDER BLADE LESION
23174	4	REMOVE HUMERUS LESION
23180	6	REMOVE COLLAR BONE LESION
23182	6	REMOVE SHOULDER BLADE LESION
23184	6	REMOVE HUMERUS LESION
23190	6	PARTIAL REMOVAL OF SCAPULA
23195	7	REMOVAL OF HEAD OF HUMERUS
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
23330	2	REMOVE SHOULDER FOREIGN BODY
23331	2	REMOVE SHOULDER FOREIGN BODY
CPT SUBSECTION: REPAIR, REVISION OR RECONSTRUCTION		
23395	7	MUSCLE TRANSFER, SHOULDER/ ARM
23397	9	MUSCLE TRANSFERS
23400	9	FIXATION OF SHOULDER BLADE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
23405	4	INCISION OF TENDON & MUSCLE
23406	4	INCISE TENDON(S) & MUSCLE(S)
23410	7	REPAIR OF TENDON(S)
23412	10	REPAIR OF TENDON(S)
23415	7	RELEASE OF SHOULDER LIGAMENT
23420	10	REPAIR OF SHOULDER
23430	6	REPAIR BICEPS TENDON
23440	6	REMOVE/TRANSPLANT TENDON
23450	7	REPAIR SHOULDER CAPSULE
23455	9	REPAIR SHOULDER CAPSULE
23460	7	REPAIR SHOULDER CAPSULE
23462	9	REPAIR SHOULDER CAPSULE
23465	7	REPAIR SHOULDER CAPSULE
23466	9	REPAIR SHOULDER CAPSULE
23480	6	REVISION OF COLLAR BONE
23485	9	REVISION OF COLLAR BONE
23490	5	REINFORCE CLAVICLE
23491	5	REINFORCE SHOULDER BONES
23500	2	TREAT CLAVICLE FRACTURE
23505	2	TREAT CLAVICLE FRACTURE
23515	5	TREAT CLAVICLE FRACTURE
23520	2	TREAT CLAVICLE DISLOCATION

CPT SUBSECTION: FRACTURE AND/OR DISLOCATION

23525	2	TREAT CLAVICLE DISLOCATION
23530	5	TREAT CLAVICLE DISLOCATION
23532	6	TREAT CLAVICLE DISLOCATION
23540	2	TREAT CLAVICLE DISLOCATION
23545	2	TREAT CLAVICLE DISLOCATION
23550	5	TREAT CLAVICLE DISLOCATION
23552	6	TREAT CLAVICLE DISLOCATION
23570	2	TREAT SHOULDER BLADE FX
23575	2	TREAT SHOULDER BLADE FX
23585	5	TREAT SCAPULA FRACTURE
23600 ⁴	2	TREAT HUMERUS FRACTURE
23605	4	TREAT HUMERUS FRACTURE
23615	6	TREAT HUMERUS FRACTURE
23616	6	TREAT HUMERUS FRACTURE
23620 ⁴	2	TREAT HUMERUS FRACTURE
23625	4	TREAT HUMERUS FRACTURE
23630	7	TREAT HUMERUS FRACTURE
23650	1	TREAT SHOULDER DISLOCATION
23655	2	TREAT SHOULDER DISLOCATION
23660	5	TREAT SHOULDER DISLOCATION
23665	4	TREAT DISLOCATION/FRACTURE
23670	5	TREAT DISLOCATION/FRACTURE
23675	4	TREAT DISLOCATION/FRACTURE
23680	5	TREAT DISLOCATION/FRACTURE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: MANIPULATION		
23700	2	FIXATION OF SHOULDER
CPT SUBSECTION: ARTHRODESIS		
23800	6	FUSION OF SHOULDER JOINT
23802	9	FUSION OF SHOULDER JOINT
CPT SUBSECTION: AMPUTATION		
23921	5	AMPUTATION FOLLOW-UP SURGERY
HUMERUS (UPPER ARM) AND ELBOW		
CPT SUBSECTION: INCISION		
23930	2	DRAINAGE OF ARM LESION
23931	4	DRAINAGE OF ARM BURSA
23935	4	DRAIN ARM/ELBOW BONE LESION
CPT SUBSECTION: EXCISION		
24000	6	EXPLORATORY ELBOW SURGERY
24006	6	RELEASE ELBOW JOINT
24066	4	BIOPSY ARM/ELBOW SOFT TISSUE
24075	4	REMOVE ARM/ELBOW LESION
24076	4	REMOVE ARM/ELBOW LESION
24077	5	REMOVE TUMOR OF ARM/ELBOW
24100	2	BIOPSY ELBOW JOINT LINING
24101	6	EXPLORE/TREAT ELBOW JOINT
24102	6	REMOVE ELBOW JOINT LINING
24105	5	REMOVAL OF ELBOW BURSA
24110	4	REMOVE HUMERUS LESION
24115	5	REMOVE/GRAFT BONE LESION
24116	5	REMOVE/GRAFT BONE LESION
24120	5	REMOVE ELBOW LESION
24125	5	REMOVE/GRAFT BONE LESION
24126	5	REMOVE/GRAFT BONE LESION
24130	5	REMOVAL OF HEAD OF RADIUS
24134	4	REMOVAL OF ARM BONE LESION
24136	4	REMOVE RADIUS BONE LESION
24138	4	REMOVE ELBOW BONE LESION
24140	5	PARTIAL REMOVAL OF ARM BONE
24145	5	PARTIAL REMOVAL OF RADIUS
24147	4	PARTIAL REMOVAL OF ELBOW
24155	5	REMOVAL OF ELBOW JOINT
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
24160	4	REMOVE ELBOW JOINT IMPLANT
24164	5	REMOVE RADIUS HEAD IMPLANT
24201	4	REMOVAL OF ARM FOREIGN BODY
CPT SUBSECTION: REPAIR, REVISION AND RECONSTRUCTION		
24301	6	MUSCLE/TENDON TRANSFER
24305	6	ARM TENDON LENGTHENING
24310	5	REVISION OF ARM TENDON
24320	5	REPAIR OF ARM TENDON

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
24330	5	REVISION OF ARM MUSCLES
24331	5	REVISION OF ARM MUSCLES
24340	5	REPAIR OF BICEPS TENDON
24341	5	REPAIR ARM TENDON/MUSCLE
24342	5	REPAIR OF RUPTURED TENDON
24345	4	REPR ELBW MED LIGMNT W/ TISSU
24350	5	REPAIR OF TENNIS ELBOW
24351	5	REPAIR OF TENNIS ELBOW
24352	5	REPAIR OF TENNIS ELBOW
24354	5	REPAIR OF TENNIS ELBOW
24356	5	REVISION OF TENNIS ELBOW
24360	7	RECONSTRUCT ELBOW JOINT
24361	7	RECONSTRUCT ELBOW JOINT
24362	7	RECONSTRUCT ELBOW JOINT
24363	9	REPLACE ELBOW JOINT
24365	7	RECONSTRUCT HEAD OF RADIUS
24366	7	RECONSTRUCT HEAD OF RADIUS
24400	6	REVISION OF HUMERUS
24410	6	REVISION OF HUMERUS
24420	5	REVISION OF HUMERUS
24430	5	REPAIR OF HUMERUS
24435	6	REPAIR HUMERUS WITH GRAFT
24470	5	REVISION OF ELBOW JOINT
24495	4	DECOMPRESSION OF FOREARM
24498	5	REINFORCE HUMERUS
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
24500	2	TREAT HUMERUS FRACTURE
24505	2	TREAT HUMERUS FRACTURE
24515	6	TREAT HUMERUS FRACTURE
24516	6	TREAT HUMERUS FRACTURE
24530	2	TREAT HUMERUS FRACTURE
24535	2	TREAT HUMERUS FRACTURE
24538	4	TREAT HUMERUS FRACTURE
24545	6	TREAT HUMERUS FRACTURE
24546	7	TREAT HUMERUS FRACTURE
24560	2	TREAT HUMERUS FRACTURE
24565	4	TREAT HUMERUS FRACTURE
24566	4	TREAT HUMERUS FRACTURE
24566	4	TREAT HUMERUS FRACTURE
24575	5	TREAT HUMERUS FRACTURE
24576	2	TREAT HUMERUS FRACTURE
24577	2	TREAT HUMERUS FRACTURE
24579	5	TREAT HUMERUS FRACTURE
24582	4	TREAT HUMERUS FRACTURE
24586	6	TREAT ELBOW FRACTURE
24587	7	TREAT ELBOW FRACTURE
24600	2	TREAT ELBOW DISLOCATION
24605	4	TREAT ELBOW DISLOCATION

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
24615	5	TREAT ELBOW DISLOCATION
24620	4	TREAT ELBOW FRACTURE
24635	5	TREAT ELBOW FRACTURE
24655	2	TREAT RADIUS FRACTURE
24665	6	TREAT RADIUS FRACTURE
24666	6	TREAT RADIUS FRACTURE
24670	2	TREAT ULNAR FRACTURE
24675	2	TREAT ULNAR FRACTURE
24685	5	TREAT ULNAR FRACTURE
CPT SUBSECTION: ARTHRODESIS		
24800	6	FUSION OF ELBOW JOINT
24802	7	FUSION/GRAFT OF ELBOW JOINT
CPT SUBSECTION: AMPUTATION		
24925	5	AMPUTATION FOLLOW-UP SURGERY
FOREARM AND WRIST		
CPT SUBSECTION: INCISION		
25000	7	INCISION OF TENDON SHEATH
25020	5	DECOMPRESS FOREARM 1 SPACE
25023	5	DECOMPRESS FOREARM 1 SPACE
25024	5	DECOMPRESS FOREARM 2 SPACES
25025	5	DECOMPRESS FOREARM 2 SPACES
25028	2	DRAINAGE OF FOREARM LESION
25031	4	DRAINAGE OF FOREARM BURSA
25035	4	TREAT FOREARM BONE LESION
25040	7	EXPLORE/TREAT WRIST JOINT
CPT SUBSECTION: EXCISION		
25066	4	BIOPSY FOREARM SOFT TISSUES
25075	4	REMOVE FOREARM LESION SUBCUT
25076	5	REMOVE FOREARM LESION DEEP
25077	5	REMOVE TUMOR, FOREARM/WRIST
25085	5	INCISION OF WRIST CAPSULE
25100	4	BIOPSY OF WRIST JOINT
25101	5	EXPLORE/TREAT WRIST JOINT
25105	6	REMOVE WRIST JOINT LINING
25107	5	REMOVE WRIST JOINT CARTILAGE
25110	5	REMOVE WRIST TENDON LESION
25111	7	REMOVE WRIST TENDON LESION
25112	6	REREMOVE WRIST TENDON LESION
25115	6	REMOVE WRIST/FOREARM LESION
25116	6	REMOVE WRIST/FOREARM LESION
25118	4	EXCISE WRIST TENDON SHEATH
25119	5	PARTIAL REMOVAL OF ULNA
25120	5	REMOVAL OF FOREARM LESION
25125	5	REMOVE/GRAFT FOREARM LESION
25126	5	REMOVE/GRAFT FOREARM LESION
25130	5	REMOVAL OF WRIST LESION

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
25135	5	REMOVE & GRAFT WRIST LESION
25136	5	REMOVE & GRAFT WRIST LESION
25145	4	REMOVE FOREARM BONE LESION
25150	4	PARTIAL REMOVAL OF ULNA
25151	4	PARTIAL REMOVAL OF RADIUS
25210	5	REMOVAL OF WRIST BONE
25215	6	REMOVAL OF WRIST BONES
25230	6	PARTIAL REMOVAL OF RADIUS
25240	6	PARTIAL REMOVAL OF ULNA
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
25248	4	REMOVE FOREARM FOREIGN BODY
25250	2	REMOVAL OF WRIST PROSTHESIS
25251	2	REMOVAL OF WRIST PROSTHESIS
CPT SUBSECTION: REPAIR, REVISION AND RECONSTRUCTION		
25260	6	REPAIR FOREARM TENDON/MUSCLE
25263	4	REPAIR FOREARM TENDON/MUSCLE
25265	5	REPAIR FOREARM TENDON/MUSCLE
25270	6	REPAIR FOREARM TENDON/MUSCLE
25272	5	REPAIR FOREARM TENDON/MUSCLE
25274	6	REPAIR FOREARM TENDON/MUSCLE
25275	6	REPAIR FOREARM TENDON SHEATH
25280	6	REVISE WRIST/FOREARM TENDON
25290	5	INCISE WRIST/FOREARM TENDON
25295	5	RELEASE WRIST/FOREARM TENDON
25300	5	FUSION OF TENDONS AT WRIST
25301	5	FUSION OF TENDONS AT WRIST
25310	5	TRANSPLANT FOREARM TENDON
25312	6	TRANSPLANT FOREARM TENDON
25315	5	REVISE PALSY HAND TENDON(S)
25316	5	REVISE PALSY HAND TENDON(S)
25320	5	REPAIR/REVISE WRIST JOINT
25332	7	REVISE WRIST JOINT
25335	5	REALIGNMENT OF HAND
25337	7	RECONSTRUCT ULNA/RADIOULNAR
25350	5	REVISION OF RADIUS
25355	5	REVISION OF RADIUS
25360	5	REVISION OF ULNA
25365	5	REVISE RADIUS & ULNA
25370	5	REVISE RADIUS OR ULNA
25375	6	REVISE RADIUS & ULNA
25390	5	SHORTEN RADIUS OR ULNA
25391	6	LENGTHEN RADIUS OR ULNA
25392	5	SHORTEN RADIUS & ULNA
25393	6	LENGTHEN RADIUS & ULNA
25400	5	REPAIR RADIUS OR ULNA
25405	6	REPAIR/GRAFT RADIUS OR ULNA
25415	5	REPAIR RADIUS & ULNA

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CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
25420	6	REPAIR/GRAFT RADIUS & ULNA
25425	5	REPAIR/GRAFT RADIUS OR ULNA
25426	6	REPAIR/GRAFT RADIUS & ULNA
25440	6	REPAIR/GRAFT WRIST BONE
25441	7	RECONSTRUCT WRIST JOINT
25442	7	RECONSTRUCT WRIST JOINT
25443	7	RECONSTRUCT WRIST JOINT
25444	7	RECONSTRUCT WRIST JOINT
25445	7	RECONSTRUCT WRIST JOINT
25446	9	WRIST REPLACEMENT
25447	7	REPAIR WRIST JOINT(S)
25449	7	REMOVE WRIST JOINT IMPLANT
25450	5	REVISION OF WRIST JOINT
25455	5	REVISION OF WRIST JOINT
25490	5	REINFORCE RADIUS
25491	5	REINFORCE ULNA
25492	5	REINFORCE RADIUS AND ULNA

CPT SUBSECTION: FRACTURE AND/OR DISLOCATION

25505	2	TREAT FRACTURE OF RADIUS
25515	5	TREAT FRACTURE OF RADIUS
25520	2	TREAT FRACTURE OF RADIUS
25525	6	TREAT FRACTURE OF RADIUS
25526	7	TREAT FRACTURE OF RADIUS
25535	2	TREAT FRACTURE OF ULNA
25545	5	TREAT FRACTURE OF ULNA
25565	2	TREAT FRACTURE RADIUS & ULNA
25574	5	TREAT FRACTURE RADIUS & ULNA
25575	5	TREAT FRACTURE RADIUS/ULNA
25605	3	TREAT FRACTURE RADIUS/ULNA
25606 ⁷	5	TREAT FX DISTAL RADIAL
25607 ⁷	7	TREAT FX RAD EXTRA-ARTICUL
25608 ⁷	7	TREAT FX RAD INTRA-ARTICUL
25609 ⁷	7	TREAT FX RADIAL 3+ FRAG
25611 ⁸	8	TREAT FRACTURE RADIUS/ULNA
25620 ⁸	7	TREAT FRACTURE RADIUS/ULNA
25624	4	TREAT WRIST BONE FRACTURE
25628	5	TREAT WRIST BONE FRACTURE
25635	2	TREAT WRIST BONE FRACTURE
25645	5	TREAT WRIST BONE FRACTURE
25660	2	TREAT WRIST DISLOCATION
25670	5	TREAT WRIST DISLOCATION
25671	2	PIN RADIOULNAR DISLOCATION
25675	2	TREAT WRIST DISLOCATION
25676	4	TREAT WRIST DISLOCATION
25680	4	TREAT WRIST FRACTURE
25685	5	TREAT WRIST FRACTURE
25690	2	TREAT WRIST DISLOCATION

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
25695	4	TREAT WRIST DISLOCATION
CPT SUBSECTION: ARTHRODESIS		
25800	6	FUSION OF WRIST JOINT
25805	7	FUSION/GRAFT OF WRIST JOINT
25810	7	FUSION/GRAFT OF WRIST JOINT
25820	6	FUSION OF HAND BONES
25825	7	FUSE HAND BONES WITH GRAFT
25830	7	FUSION, RADIOULNAR JNT/ULNA
CPT SUBSECTION: AMPUTATION		
25907	5	AMPUTATION FOLLOW-UP SURGERY
25922	5	AMPUTATE HAND AT WRIST
25929	5	AMPUTATION FOLLOW-UP SURGERY
HANDS AND FINGERS		
CPT SUBSECTION: INCISION		
26011	2	DRAINAGE OF FINGER ABSCESS
26020	4	DRAIN HAND TENDON SHEATH
26025	2	DRAINAGE OF PALM BURSA
CPT SUBSECTION: ARTHRODESIS		
26030	4	DRAINAGE OF PALM BURSA(S)
26034	4	TREAT HAND BONE LESION
26040	6	RELEASE PALM CONTRACTURE
26045	5	RELEASE PALM CONTRACTURE
26055	6	INCISE FINGER TENDON SHEATH
26060	4	INCISION OF FINGER TENDON
26070	4	EXPLORE/TREAT HAND JOINT
26075	6	EXPLORE/TREAT FINGER JOINT
26080	6	EXPLORE/TREAT FINGER JOINT
CPT SUBSECTION: EXCISION		
26100	4	BIOPSY HAND JOINT LINING
26105	2	BIOPSY FINGER JOINT LINING
26110	2	BIOPSY FINGER JOINT LINING
26115	4	REMOVE HAND LESION SUBCUT
26116	4	REMOVE HAND LESION, DEEP
26117	5	REMOVE TUMOR, HAND/FINGER
26121	6	RELEASE PALM CONTRACTURE
26123	6	RELEASE PALM CONTRACTURE
26125	6	RELEASE PALM CONTRACTURE
26130	5	REMOVE WRIST JOINT LINING
26135	6	REVISE FINGER JOINT, EACH
26140	4	REVISE FINGER JOINT, EACH
26145	5	TENDON EXCISION, PALM/FINGER
26160	6	REMOVE TENDON SHEATH LESION
26170	5	REMOVAL OF PALM TENDON, EACH
26180	5	REMOVAL OF FINGER TENDON
26185	6	REMOVE FINGER BONE
26200	4	REMOVE HAND BONE LESION

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
26205	5	REMOVE/GRAFT BONE LESION
26210	4	REMOVAL OF FINGER LESION
26215	5	REMOVE/GRAFT FINGER LESION
26230	9	PARTIAL REMOVAL OF HAND BONE
26235	5	PARTIAL REMOVAL, FINGER BONE
26236	5	PARTIAL REMOVAL, FINGER BONE
26250	5	EXTENSIVE HAND SURGERY
26255	5	EXTENSIVE HAND SURGERY
26260	5	EXTENSIVE FINGER SURGERY
26261	5	EXTENSIVE FINGER SURGERY
26262	4	PARTIAL REMOVAL OF FINGER
CPT SUBSECTION: INTRODUCTION OR REMOVAL		
26320	4	REMOVAL OF IMPLANT FROM HAND
CPT SUBSECTION: REPAIR, REVISION AND RECONSTRUCTION		
26350	2	REPAIR FINGER/HAND TENDON
26352	6	REPAIR/GRAFT HAND TENDON
26356	6	REPAIR FINGER/HAND TENDON
26357	6	REPAIR FINGER/HAND TENDON
26358	6	REPAIR/GRAFT HAND TENDON
26370	6	REPAIR FINGER/HAND TENDON
26372	6	REPAIR/GRAFT HAND TENDON
26373	5	REPAIR FINGER/HAND TENDON
26390	6	REVISE HAND/FINGER TENDON
26392	5	REPAIR/GRAFT HAND TENDON
26410	5	REPAIR HAND TENDON
26412	5	REPAIR/GRAFT HAND TENDON
26415	6	EXCISION, HAND/FINGER TENDON
26416	5	GRAFT HAND OR FINGER TENDON
26418	6	REPAIR FINGER TENDON
26420	6	REPAIR/GRAFT FINGER TENDON
26426	5	REPAIR FINGER/HAND TENDON
26428	5	REPAIR/GRAFT FINGER TENDON
26432	5	REPAIR FINGER TENDON
26433	5	REPAIR FINGER TENDON
26434	5	REPAIR/GRAFT FINGER TENDON
26437	5	REALIGNMENT OF TENDONS
26440	5	RELEASE PALM/FINGER TENDON
26442	5	RELEASE PALM & FINGER TENDON
26445	5	RELEASE HAND/FINGER TENDON
26449	5	RELEASE FOREARM/HAND TENDON
26450	5	INCISION OF PALM TENDON
26455	5	INCISION OF FINGER TENDON
26460	5	INCISE HAND/FINGER TENDON
26471	4	FUSION OF FINGER TENDONS
26474	4	FUSION OF FINGER TENDONS
26476	2	TENDON LENGTHENING
26477	2	TENDON SHORTENING

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CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
26478	2	LENGTHENING OF HAND TENDON
26479	2	SHORTENING OF HAND TENDON
26480	5	TRANSPLANT HAND TENDON
26483	5	TRANSPLANT/GRAFT HAND TENDON
26485	4	TRANSPLANT PALM TENDON
26489	5	TRANSPLANT/GRAFT PALM TENDON
26490	5	REVISE THUMB TENDON
26492	5	TENDON TRANSFER WITH GRAFT
26494	5	HAND TENDON/MUSCLE TRANSFER
26496	5	REVISE THUMB TENDON
26497	5	FINGER TENDON TRANSFER
26498	6	FINGER TENDON TRANSFER
26499	5	REVISION OF FINGER
26500	6	HAND TENDON RECONSTRUCTION
26502	6	HAND TENDON RECONSTRUCTION
26504 ⁸	6	HAND TENDON RECONSTRUCTION
26508	5	RELEASE THUMB CONTRACTURE
26510	5	THUMB TENDON TRANSFER
26516	2	FUSION OF KNUCKLE JOINT
26517	5	FUSION OF KNUCKLE JOINTS
26518	5	FUSION OF KNUCKLE JOINTS
26520	5	RELEASE KNUCKLE CONTRACTURE
26525	5	RELEASE FINGER CONTRACTURE
26530	5	REVISE KNUCKLE JOINT
26531	9	REVISE KNUCKLE WITH IMPLANT
26535	7	REVISE FINGER JOINT
26536	7	REVISE/IMPLANT FINGER JOINT
26540	6	REPAIR HAND JOINT
26541	9	REPAIR HAND JOINT WITH GRAFT
26542	6	REPAIR HAND JOINT WITH GRAFT
26545	6	RECONSTRUCT FINGER JOINT
26546	6	REPAIR NONUNION HAND
26548	6	RECONSTRUCT FINGER JOINT
26550	4	CONSTRUCT THUMB REPLACEMENT
26555	5	POSITIONAL CHANGE OF FINGER
26560	4	REPAIR OF WEB FINGER
26561	5	REPAIR OF WEB FINGER
26562	6	REPAIR OF WEB FINGER
26565	7	CORRECT METACARPAL FLAW
26567	7	CORRECT FINGER DEFORMITY
26568	5	LENGTHEN METACARPAL/FINGER
26580	7	REPAIR HAND DEFORMITY
26587	7	RECONSTRUCT EXTRA FINGER
26590	7	REPAIR FINGER DEFORMITY
26591	5	REPAIR MUSCLES OF HAND
26593	5	RELEASE MUSCLES OF HAND
26596	4	EXCISION CONSTRICTING TISSUE

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: FRACTURE AND/OR DISLOCATION		
26605	4	TREAT METACARPAL FRACTURE
26607	4	TREAT METACARPAL FRACTURE
26608	6	TREAT METACARPAL FRACTURE
26615	6	TREAT METACARPAL FRACTURE
26645	2	TREAT THUMB FRACTURE
26650	4	TREAT THUMB FRACTURE
26665	6	TREAT THUMB FRACTURE
26675	4	TREAT HAND DISLOCATION
26676	4	PIN HAND DISLOCATION
26685	5	TREAT HAND DISLOCATION
26686	5	TREAT HAND DISLOCATION
26705	4	TREAT KNUCKLE DISLOCATION
26706	4	PIN KNUCKLE DISLOCATION
26715	6	TREAT KNUCKLE DISLOCATION
26727	9	TREAT FINGER FRACTURE, EACH
26735	6	TREAT FINGER FRACTURE, EACH
26742	4	TREAT FINGER FRACTURE, EACH
26746	7	TREAT FINGER FRACTURE, EACH
26756	4	PIN FINGER FRACTURE, EACH
26765	6	TREAT FINGER FRACTURE, EACH
26776	4	PIN FINGER DISLOCATION
26785	4	TREAT FINGER DISLOCATION
CPT SUBSECTION: ARTHRODESIS		
26820	7	THUMB FUSION WITH GRAFT
26841	6	FUSION OF THUMB
26842	6	THUMB FUSION WITH GRAFT
26843	5	FUSION OF HAND JOINT
26844	5	FUSION/GRAFT OF HAND JOINT
26850	6	FUSION OF KNUCKLE
26852	6	FUSION OF KNUCKLE WITH GRAFT
26860	5	FUSION OF FINGER JOINT
26861	4	FUSION OF FINGER JNT, ADD-ON
26862	6	FUSION/GRAFT OF FINGER JOINT
26863	5	FUSE/GRAFT ADDED JOINT
CPT SUBSECTION: AMPUTATION		
26910	5	AMPUTATE METACARPAL BONE
26951	4	AMPUTATION OF FINGER/THUMB
26952	6	AMPUTATION OF FINGER/THUMB
PELVIS AND HIP JOINT		
CPT SUBSECTION: INCISION		
26990	2	DRAINAGE OF PELVIS LESION
26991	2	DRAINAGE OF PELVIS BURSA
27000	4	INCISION OF HIP TENDON
27001	5	INCISION OF HIP TENDON
27003	5	INCISION OF HIP TENDON
27033	5	EXPLORATION OF HIP JOINT

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
27035	6	DENERVATION OF HIP JOINT
CPT SUBSECTION: EXCISION		
27040	2	BIOPSY OF SOFT TISSUES
27041	4	BIOPSY OF SOFT TISSUES
27047	4	REMOVE HIP/PELVIS LESION
27048	5	REMOVE HIP/PELVIS LESION
27049	5	REMOVE TUMOR, HIP/PELVIS
27050	5	BIOPSY OF SACROILIAC JOINT
27052	5	BIOPSY OF HIP JOINT
27060	7	REMOVAL OF ISCHIAL BURSA
27062	7	REMOVE FEMUR LESION/BURSA
27065	7	REMOVAL OF HIP BONE LESION
27066	7	REMOVAL OF HIP BONE LESION
27067	7	REMOVE/GRAFT HIP BONE LESION
27080	4	REMOVAL OF TAIL BONE
CPT SUBSECTION: PRODUCTION AND/OR REMOVAL		
27086	2	REMOVE HIP FOREIGN BODY
27087	5	REMOVE HIP FOREIGN BODY
CPT SUBSECTION: REPAIR, REVISION AND RECONSTRUCTION		
27097	5	REVISION OF HIP TENDON
27098	5	TRANSFER TENDON TO PELVIS
27100	6	TRANSFER OF ABDOMINAL MUSCLE
27105	6	TRANSFER OF SPINAL MUSCLE
27110	6	TRANSFER OF ILIOPSOAS MUSCLE
27111	6	TRANSFER OF ILIOPSOAS MUSCLE
CPT SUBSECTION: FRACTURES AND/OR DISLOCATIONS		
27193	2	TREAT PELVIC RING FRACTURE
27194	4	TREAT PELVIC RING FRACTURE
27202	4	TREAT TAIL BONE FRACTURE
27230	2	TREAT THIGH FRACTURE
27238	2	TREAT THIGH FRACTURE
27246	2	TREAT THIGH FRACTURE
27250	2	TREAT HIP DISLOCATION
27252	2	TREAT HIP DISLOCATION
27257	5	TREAT HIP DISLOCATION
27265	2	TREAT HIP DISLOCATION
27266	4	TREAT HIP DISLOCATION
CPT SUBSECTION: MANIPULATION		
27275	4	MANIPULATION OF HIP JOINT
FEMUR (THIGH REGION) AND KNEE JOINT		
CPT SUBSECTION: INCISION		
27301	5	DRAIN THIGH/KNEE LESION
27305	4	INCISE THIGH TENDON & FASCIA
27306	5	INCISION OF THIGH TENDON
27307	5	INCISION OF THIGH TENDONS
27310	6	EXPLORATION OF KNEE JOINT

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
27315 ⁸	4	PARTIAL REMOVAL, THIGH NERVE
27320 ⁸	4	PARTIAL REMOVAL, THIGH NERVE
27325 ⁷	4	NEURECTOMY, HAMSTRING
27326 ⁷	4	NEURECTOMY, POPLITEAL
CPT SUBSECTION: EXCISION		
27323	2	BIOPSY, THIGH SOFT TISSUES
27324	2	BIOPSY, THIGH SOFT TISSUES
27327	4	REMOVAL OF THIGH LESION
27328	5	REMOVAL OF THIGH LESION
27329	6	REMOVE TUMOR, THIGH/KNEE
27330	6	BIOPSY, KNEE JOINT LINING
27331	6	EXPLORE/TREAT KNEE JOINT
27332	6	REMOVAL OF KNEE CARTILAGE
27333	6	REMOVAL OF KNEE CARTILAGE
27334	6	REMOVE KNEE JOINT LINING
27335	6	REMOVE KNEE JOINT LINING
27340	5	REMOVAL OF KNEECAP BURSA
27345	6	REMOVAL OF KNEE CYST
27347	6	REMOVE KNEE CYST
27350	6	REMOVAL OF KNEECAP
27355	5	REMOVE FEMUR LESION
27356	6	REMOVE FEMUR LESION/GRAFT
27357	7	REMOVE FEMUR LESION/GRAFT
27358	7	REMOVE FEMUR LESION/FIXATION
27360	7	PARTIAL REMOVAL, LEG BONE(S)
CPT SUBSECTION: INTRODUCTION AND/OR REMOVAL		
27372	9	REMOVAL OF FOREIGN BODY
CPT SUBSECTION: REPAIR, REVISION AND RECONSTRUCTION		
27380	2	REPAIR OF KNEECAP TENDON
27381	5	REPAIR/GRAFT KNEECAP TENDON
27385	5	REPAIR OF THIGH MUSCLE
27386	5	REPAIR/GRAFT OF THIGH MUSCLE
27390	2	INCISION OF THIGH TENDON
27391	4	INCISION OF THIGH TENDONS
27392	5	INCISION OF THIGH TENDONS
27393	4	LENGTHENING OF THIGH TENDON
27394	5	LENGTHENING OF THIGH TENDONS
27395	5	LENGTHENING OF THIGH TENDONS
27396	5	TRANSPLANT OF THIGH TENDON
27397	5	TRANSPLANTS OF THIGH TENDONS
27400	5	REVISE THIGH MUSCLES/TENDONS
27403	6	REPAIR OF KNEE CARTILAGE
27405	6	REPAIR OF KNEE LIGAMENT
27407	6	REPAIR OF KNEE LIGAMENT
27409	6	REPAIR OF KNEE LIGAMENTS
27418	5	REPAIR DEGENERATED KNEECAP
27420	5	REVISION OF UNSTABLE KNEECAP

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
27422	9	REVISION OF UNSTABLE KNEECAP
27424	5	REVISION/REMOVAL OF KNEECAP
27425	9	LAT RETINACULAR RELEASE OPEN
27427	5	RECONSTRUCTION, KNEE
27428	6	RECONSTRUCTION, KNEE
27429	6	RECONSTRUCTION, KNEE
27430	6	REVISION OF THIGH MUSCLES
27435	6	INCISION OF KNEE JOINT
27437	6	REVISE KNEECAP
27438	7	REVISE KNEECAP WITH IMPLANT
27441	7	REVISION OF KNEE JOINT
27442	7	REVISION OF KNEE JOINT
27443	7	REVISION OF KNEE JOINT
27496	7	DECOMPRESSION OF THIGH/KNEE
27497	5	DECOMPRESSION OF THIGH/KNEE
27498	5	DECOMPRESSION OF THIGH/KNEE
27499	5	DECOMPRESSION OF THIGH/KNEE
CPT SUBSECTION: FRACTURES AND/OR DISLOCATIONS		
27500	2	TREATMENT OF THIGH FRACTURE
27501	4	TREATMENT OF THIGH FRACTURE
27502	4	TREATMENT OF THIGH FRACTURE
27503	5	TREATMENT OF THIGH FRACTURE
27508	2	TREATMENT OF THIGH FRACTURE
27509	5	TREATMENT OF THIGH FRACTURE
27510	2	TREATMENT OF THIGH FRACTURE
27516	2	TREAT THIGH FX GROWTH PLATE
27517	2	TREAT THIGH FX GROWTH PLATE
27520	2	TREAT KNEECAP FRACTURE
27530	2	TREAT KNEE FRACTURE
27532	2	TREAT KNEE FRACTURE
27538	2	TREAT KNEE FRACTURE(S)
27550	2	TREAT KNEE DISLOCATION
27552	2	TREAT KNEE DISLOCATION
27560	2	TREAT KNEECAP DISLOCATION
27562	2	TREAT KNEECAP DISLOCATION
27566	4	TREAT KNEECAP DISLOCATION
CPT SUBSECTION: MANIPULATION		
27570	2	FIXATION OF KNEE JOINT
CPT SUBSECTION: AMPUTATION		
27594	5	AMPUTATION FOLLOW-UP SURGERY
LEG (TIBIA AND FIBULA) AND ANKLE JOINT		
CPT SUBSECTION: INCISION		
27600	5	DECOMPRESSION OF LOWER LEG
27601	5	DECOMPRESSION OF LOWER LEG
27602	5	DECOMPRESSION OF LOWER LEG
27603	4	DRAIN LOWER LEG LESION

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
27604	4	DRAIN LOWER LEG BURSA
27605	2	INCISION OF ACHILLES TENDON
27606	2	INCISION OF ACHILLES TENDON
27607	4	TREAT LOWER LEG BONE LESION
27610	4	EXPLORE/TREAT ANKLE JOINT
27612	5	EXPLORATION OF ANKLE JOINT
CPT SUBSECTION: EXCISION		
27614	4	BIOPSY LOWER LEG SOFT TISSUE
27615	5	REMOVE TUMOR, LOWER LEG
27618	4	REMOVE LOWER LEG LESION
27619	5	REMOVE LOWER LEG LESION
27620	6	EXPLORE/TREAT ANKLE JOINT
27625	6	REMOVE ANKLE JOINT LINING
27626	6	REMOVE ANKLE JOINT LINING
27630	5	REMOVAL OF TENDON LESION
27635	5	REMOVE LOWER LEG BONE LESION
27637	5	REMOVE/GRAFT LEG BONE LESION
27638	5	REMOVE/GRAFT LEG BONE LESION
27640	4	PARTIAL REMOVAL OF TIBIA
27641	4	PARTIAL REMOVAL OF FIBULA
27647	5	EXTENSIVE ANKLE/HEEL SURGERY
CPT SUBSECTION: REPAIR, REVISION OR RECONSTRUCTION		
27650	9	REPAIR ACHILLES TENDON
27652	5	REPAIR/GRAFT ACHILLES TENDON
27654	5	REPAIR OF ACHILLES TENDON
27656	4	REPAIR LEG FASCIA DEFECT
27658	2	REPAIR OF LEG TENDON, EACH
27659	4	REPAIR OF LEG TENDON, EACH
27664	4	REPAIR OF LEG TENDON, EACH
27665	4	REPAIR OF LEG TENDON, EACH
27675	4	REPAIR LOWER LEG TENDONS
27676	5	REPAIR LOWER LEG TENDONS
27680	5	RELEASE OF LOWER LEG TENDON
27681	4	RELEASE OF LOWER LEG TENDONS
27685	5	REVISION OF LOWER LEG TENDON
27686	5	REVISE LOWER LEG TENDONS
27687	5	REVISION OF CALF TENDON
27690	6	REVISE LOWER LEG TENDON
27691	6	REVISE LOWER LEG TENDON
27692	5	REVISE ADDITIONAL LEG TENDON
27695	4	REPAIR OF ANKLE LIGAMENT
27696	4	REPAIR OF ANKLE LIGAMENTS
27698	4	REPAIR OF ANKLE LIGAMENT
27700	7	REVISION OF ANKLE JOINT
27704	4	REMOVAL OF ANKLE IMPLANT
27705	4	INCISION OF TIBIA
27707	4	INCISION OF FIBULA

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
27709	4	INCISION OF TIBIA & FIBULA
27730	4	REPAIR OF TIBIA EPIPHYSIS
27732	4	REPAIR OF FIBULA EPIPHYSIS
27734	4	REPAIR LOWER LEG EPIPHYSES
27740	4	REPAIR OF LEG EPIPHYSES
27742	4	REPAIR OF LEG EPIPHYSES
27745	5	REINFORCE TIBIA
CPT SUBSECTION: FRACTURES AND/OR DISLOCATIONS		
27750	2	TREATMENT OF TIBIA FRACTURE
27752	2	TREATMENT OF TIBIA FRACTURE
27756	5	TREATMENT OF TIBIA FRACTURE
27758	6	TREATMENT OF TIBIA FRACTURE
27759	6	TREATMENT OF TIBIA FRACTURE
27760	2	TREATMENT OF ANKLE FRACTURE
27762	2	TREATMENT OF ANKLE FRACTURE
27766	5	TREATMENT OF ANKLE FRACTURE
27780	2	TREATMENT OF FIBULA FRACTURE
27781	2	TREATMENT OF FIBULA FRACTURE
27784	5	TREATMENT OF FIBULA FRACTURE
27786	2	TREATMENT OF ANKLE FRACTURE
27788	2	TREATMENT OF ANKLE FRACTURE
27792	5	TREATMENT OF ANKLE FRACTURE
27808	2	TREATMENT OF ANKLE FRACTURE
27810	2	TREATMENT OF ANKLE FRACTURE
27814	5	TREATMENT OF ANKLE FRACTURE
27816	2	TREATMENT OF ANKLE FRACTURE
27818	2	TREATMENT OF ANKLE FRACTURE
27822	5	TREATMENT OF ANKLE FRACTURE
27823	5	TREATMENT OF ANKLE FRACTURE
27824	2	TREAT LOWER LEG FRACTURE
27825	4	TREAT LOWER LEG FRACTURE
27826	5	TREAT LOWER LEG FRACTURE
27827	5	TREAT LOWER LEG FRACTURE
27828	6	TREAT LOWER LEG FRACTURE
27829	4	TREAT LOWER LEG JOINT
27830	2	TREAT LOWER LEG DISLOCATION
27831	2	TREAT LOWER LEG DISLOCATION
27832	4	TREAT LOWER LEG DISLOCATION
27840	2	TREAT ANKLE DISLOCATION
27842	2	TREAT ANKLE DISLOCATION
27846	5	TREAT ANKLE DISLOCATION
27848	5	TREAT ANKLE DISLOCATION
CPT SUBSECTION: MANIPULATION		
27860	2	FIXATION OF ANKLE JOINT
CPT SUBSECTION: ARTHRODESIS		
27870	6	FUSION OF ANKLE JOINT
27871	6	FUSION OF TIBIOFIBULAR JOINT

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: AMPUTATION		
27884	5	AMPUTATION FOLLOW-UP SURGERY
27889	5	AMPUTATION OF FOOT AT ANKLE
CPT SUBSECTION: OTHER PROCEDURES		
27892	5	DECOMPRESSION OF LEG
27893	5	DECOMPRESSION OF LEG
27894	5	DECOMPRESSION OF LEG
Foot		
CPT SUBSECTION: INCISION		
28002	5	TREATMENT OF FOOT INFECTION
28003	5	TREATMENT OF FOOT INFECTION
28005	5	TREAT FOOT BONE LESION
28008	5	INCISION OF FOOT FASCIA
28011	5	INCISION OF TOE TENDONS
28020	4	EXPLORATION OF FOOT JOINT
28022	4	EXPLORATION OF FOOT JOINT
28024	4	EXPLORATION OF TOE JOINT
28030 ⁸	6	REMOVAL OF FOOT NERVE
28035	6	DECOMPRESSION OF TIBIA NERVE
CPT SUBSECTION: EXCISION		
28043	4	EXCISION OF FOOT LESION
28045	5	EXCISION OF FOOT LESION
28046	5	RESECTION OF TUMOR, FOOT
28050	4	BIOPSY OF FOOT JOINT LINING
28052	4	BIOPSY OF FOOT JOINT LINING
28054	4	BIOPSY OF TOE JOINT LINING
28055 ⁷	6	NEURECTOMY, FOOT
28060	4	PARTIAL REMOVAL, FOOT FASCIA
28062	5	REMOVAL OF FOOT FASCIA
28070	5	REMOVAL OF FOOT JOINT LINING
28072	5	REMOVAL OF FOOT JOINT LINING
28080	8	REMOVAL OF FOOT LESION
28086	4	EXCISE FOOT TENDON SHEATH
28088	4	EXCISE FOOT TENDON SHEATH
28090	7	REMOVAL OF FOOT LESION
28092	5	REMOVAL OF TOE LESIONS
28100	4	REMOVAL OF ANKLE/HEEL LESION
28102	5	REMOVE/GRAFT FOOT LESION
28103	5	REMOVE/GRAFT FOOT LESION
28104	4	REMOVAL OF FOOT LESION
28106	5	REMOVE/GRAFT FOOT LESION
28107	5	REMOVE/GRAFT FOOT LESION
28108 ³	4	REMOVAL OF TOE LESIONS
28110	5	PART REMOVAL OF METATARSAL
28111	5	PART REMOVAL OF METATARSAL
28112	5	PART REMOVAL OF METATARSAL
28113	5	PART REMOVAL OF METATARSAL

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
28114	5	REMOVAL OF METATARSAL HEADS
28116	5	REVISION OF FOOT
28118	6	REMOVAL OF HEEL BONE
28119	9	REMOVAL OF HEEL SPUR
28120	9	PART REMOVAL OF ANKLE/HEEL
28122	5	PARTIAL REMOVAL OF FOOT BONE
28126	5	PARTIAL REMOVAL OF TOE
28130	5	REMOVAL OF ANKLE BONE
28140	5	REMOVAL OF METATARSAL
28150	5	REMOVAL OF TOE
28153	5	PARTIAL REMOVAL OF TOE
28160	5	PARTIAL REMOVAL OF TOE
28171	5	EXTENSIVE FOOT SURGERY
28173	5	EXTENSIVE FOOT SURGERY
28175	5	EXTENSIVE FOOT SURGERY
28192	4	REMOVAL OF FOOT FOREIGN BODY
28193	6	REMOVAL OF FOOT FOREIGN BODY
CPT SUBSECTION: REPAIR, REVISION OR RECONSTRUCTION		
28200	5	REPAIR OF FOOT TENDON
28202	5	REPAIR/GRAFT OF FOOT TENDON
28208	5	REPAIR OF FOOT TENDON
28210	5	REPAIR/GRAFT OF FOOT TENDON
28222	2	RELEASE OF FOOT TENDONS
28225	2	RELEASE OF FOOT TENDON
28226	2	RELEASE OF FOOT TENDONS
28234	4	INCISION OF FOOT TENDON
28238	5	REVISION OF FOOT TENDON
28240	4	RELEASE OF BIG TOE
28250	5	REVISION OF FOOT FASCIA
28260	5	RELEASE OF MIDFOOT JOINT
28261	5	REVISION OF FOOT TENDON
28262	6	REVISION OF FOOT AND ANKLE
28264	2	RELEASE OF MIDFOOT JOINT
28270	5	RELEASE OF FOOT CONTRACTURE
28280	4	FUSION OF TOES
28285	8	REPAIR OF HAMMERTOES
28286	6	REPAIR OF HAMMERTOES
28288	5	PARTIAL REMOVAL OF FOOT BONE
28289	5	REPAIR HALLUX RIGIDUS
28290	4	CORRECTION OF BUNION
28292	9	CORRECTION OF BUNION
28293	5	CORRECTION OF BUNION
28294	5	CORRECTION OF BUNION
28296	9	CORRECTION OF BUNION
28297	5	CORRECTION OF BUNION
28298	5	CORRECTION OF BUNION
28299	10	CORRECTION OF BUNION

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
28300	4	INCISION OF HEEL BONE
28302	4	INCISION OF ANKLE BONE
28304	4	INCISION OF MIDFOOT BONES
28305	5	INCISE/GRAFT MIDFOOT BONES
28306	6	INCISION OF METATARSAL
28307	6	INCISION OF METATARSAL
28308	4	INCISION OF METATARSAL
28309	6	INCISION OF METATARSALS
28310	5	REVISION OF BIG TOE
28312	5	REVISION OF TOE
28313	4	REPAIR DEFORMITY OF TOE
28315	6	REMOVAL OF SESAMOID BONE
28320	6	REPAIR OF FOOT BONES
28322	6	REPAIR OF METATARSALS
28340	6	RESECT ENLARGED TOE TISSUE
28341	6	RESECT ENLARGED TOE
28344	6	REPAIR EXTRA TOE(S)
28345	6	REPAIR WEBBED TOE(S)
CPT SUBSECTION: FRACTURES AND/OR DISLOCATIONS		
28400	2	TREATMENT OF HEEL FRACTURE
28405	4	TREATMENT OF HEEL FRACTURE
28406	4	TREATMENT OF HEEL FRACTURE
28415	5	TREAT HEEL FRACTURE
28420	6	TREAT/GRAFT HEEL FRACTURE
28435	4	TREATMENT OF ANKLE FRACTURE
28436	4	TREATMENT OF ANKLE FRACTURE
28445	5	TREAT ANKLE FRACTURE
28456	4	TREAT MIDFOOT FRACTURE
28465	5	TREAT MIDFOOT FRACTURE, EACH
28476	4	TREAT METATARSAL FRACTURE
28485	6	TREAT METATARSAL FRACTURE
28496	4	TREAT BIG TOE FRACTURE
28505	5	TREAT BIG TOE FRACTURE
28525	5	TREAT TOE FRACTURE
28531	5	TREAT SESAMOID BONE FRACTURE
28545	2	TREAT FOOT DISLOCATION
28546	4	TREAT FOOT DISLOCATION
28555	4	REPAIR FOOT DISLOCATION
28575	2	TREAT FOOT DISLOCATION
28576	5	TREAT FOOT DISLOCATION
28585	5	REPAIR FOOT DISLOCATION
28605	2	TREAT FOOT DISLOCATION
28606	4	TREAT FOOT DISLOCATION
28615	5	REPAIR FOOT DISLOCATION
28635	2	TREAT TOE DISLOCATION
28636	5	TREAT TOE DISLOCATION
28645	5	REPAIR TOE DISLOCATION

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
28665	2	TREAT TOE DISLOCATION
28666	5	TREAT TOE DISLOCATION
28675	5	REPAIR OF TOE DISLOCATION
CPT SUBSECTION: ARTHRODESIS		
28705	6	FUSION OF FOOT BONES
28715	6	FUSION OF FOOT BONES
28725	6	FUSION OF FOOT BONES
28730	6	FUSION OF FOOT BONES
28735	6	FUSION OF FOOT BONES
28737	7	REVISION OF FOOT BONES
28740	6	FUSION OF FOOT BONES
28750	6	FUSION OF BIG TOE JOINT
28755	6	FUSION OF BIG TOE JOINT
28760	6	FUSION OF BIG TOE JOINT
CPT SUBSECTION: AMPUTATION		
28810	4	AMPUTATION TOE & METATARSAL
28820	4	AMPUTATION OF TOE
28825	4	PARTIAL AMPUTATION OF TOE
CPT SUBSECTION: ARTHROSCOPY		
29800	5	JAW ARTHROSCOPY/SURGERY
29804	5	JAW ARTHROSCOPY/SURGERY
29805	5	SHOULDER ARTHROSCOPY, DX
29806	5	SHOULDER ARTHROSCOPY/SURGERY
29807	5	SHOULDER ARTHROSCOPY/SURGERY
29819	5	SHOULDER ARTHROSCOPY/SURGERY
29820	5	SHOULDER ARTHROSCOPY/SURGERY
29821	5	SHOULDER ARTHROSCOPY/SURGERY
29822	5	SHOULDER ARTHROSCOPY/SURGERY
29823	5	SHOULDER ARTHROSCOPY/SURGERY
29824	7	SHOULDER ARTHROSCOPY/SURGERY
29825	5	SHOULDER ARTHROSCOPY/SURGERY
29826	10	SHOULDER ARTHROSCOPY/SURGERY
29827	7	ARTHROSCOP ROTATOR CUFF REPR
29830	5	ELBOW ARTHROSCOPY
29834	5	ELBOW ARTHROSCOPY/SURGERY
29835	5	ELBOW ARTHROSCOPY/SURGERY
29836	5	ELBOW ARTHROSCOPY/SURGERY
29837	5	ELBOW ARTHROSCOPY/SURGERY
29838	5	ELBOW ARTHROSCOPY/SURGERY
29840	5	WRIST ARTHROSCOPY
29843	5	WRIST ARTHROSCOPY/SURGERY
29844	5	WRIST ARTHROSCOPY/SURGERY
29845	5	WRIST ARTHROSCOPY/SURGERY
29846	5	WRIST ARTHROSCOPY/SURGERY
29847	5	WRIST ARTHROSCOPY/SURGERY
29848	10	WRIST ENDOSCOPY/SURGERY
29850	6	KNEE ARTHROSCOPY/SURGERY

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MUSCULOSKELETAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
29851	6	KNEE ARTHROSCOPY/SURGERY
29855	6	TIBIAL ARTHROSCOPY/SURGERY
29856	6	TIBIAL ARTHROSCOPY/SURGERY
29860	6	HIP ARTHROSCOPY, DX
29861	6	HIP ARTHROSCOPY/SURGERY
29862	10	HIP ARTHROSCOPY/SURGERY
29863	6	HIP ARTHROSCOPY/SURGERY
29870	9	KNEE ARTHROSCOPY, DX
29871	5	KNEE ARTHROSCOPY/DRAINAGE
29873 ³	5	KNEE ARTHROSCOPY/SURGERY
29874	5	KNEE ARTHROSCOPY/SURGERY
29875	9	KNEE ARTHROSCOPY/SURGERY
29876	9	KNEE ARTHROSCOPY/SURGERY
29877	9	KNEE ARTHROSCOPY/SURGERY
29879	9	KNEE ARTHROSCOPY/SURGERY
29880	9	KNEE ARTHROSCOPY/SURGERY
29881	9	KNEE ARTHROSCOPY/SURGERY
29882	9	KNEE ARTHROSCOPY/SURGERY
29883	5	KNEE ARTHROSCOPY/SURGERY
29884	5	KNEE ARTHROSCOPY/SURGERY
29885	5	KNEE ARTHROSCOPY/SURGERY
29886	5	KNEE ARTHROSCOPY/SURGERY
29887	5	KNEE ARTHROSCOPY/SURGERY
29888	9	KNEE ARTHROSCOPY/SURGERY
29889	5	KNEE ARTHROSCOPY/SURGERY
29891	5	ANKLE ARTHROSCOPY/SURGERY
29892	5	ANKLE ARTHROSCOPY/SURGERY
29893	10	SCOPE, PLANTAR FASCIOTOMY
29894	5	ANKLE ARTHROSCOPY/SURGERY
29895	5	ANKLE ARTHROSCOPY/SURGERY
29897	5	ANKLE ARTHROSCOPY/SURGERY
29898	5	ANKLE ARTHROSCOPY/SURGERY
29899	5	ANKLE ARTHROSCOPY/SURGERY
29900	5	MCP JOINT ARTHROSCOPY, DX
29901	5	MCP JOINT ARTHROSCOPY, SURG
29902	5	MCP JOINT ARTHROSCOPY, SURG

RESPIRATORY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
NOSE		
CPT SUBSECTION: EXCISION		
30115	4	REMOVAL OF NOSE POLYP(S)
30117	5	REMOVAL OF INTRANASAL LESION
30118	5	REMOVAL OF INTRANASAL LESION
30120	3	REVISION OF NOSE
30125	4	REMOVAL OF NOSE LESION

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RESPIRATORY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
30130	5	REMOVAL OF TURBINATE BONES
30140	5	REMOVAL OF TURBINATE BONES
30150	5	PARTIAL REMOVAL OF NOSE
30160	6	REMOVAL OF NOSE
CPT SUBSECTION: INTRODUCTION		
30220 ³	5	INSERT NASAL SEPTAL BUTTON
CPT SUBSECTION: REMOVAL FOREIGN BODY		
30310	2	REMOVE NASAL FOREIGN BODY
30320	4	REMOVE NASAL FOREIGN BODY
CPT SUBSECTION: REPAIR		
30400	6	RECONSTRUCTION OF NOSE
30410	7	RECONSTRUCTION OF NOSE
30420	7	RECONSTRUCTION OF NOSE
30430	5	REVISION OF NOSE
30435	7	REVISION OF NOSE
30450	9	REVISION OF NOSE
30460	9	REVISION OF NOSE
30462	10	REVISION OF NOSE
30465	10	REPAIR NASAL STENOSIS
30520	8	REPAIR OF NASAL SEPTUM
30540	7	REPAIR NASAL DEFECT
30545	7	REPAIR NASAL DEFECT
30560	4	RELEASE OF NASAL ADHESIONS
30580	6	REPAIR UPPER JAW FISTULA
30600	6	REPAIR MOUTH/NOSE FISTULA
30620	9	INTRANASAL RECONSTRUCTION
30630	9	REPAIR NASAL SEPTUM DEFECT
30801	2	CAUTERIZATION, INNER NOSE
30802	2	CAUTERIZATION, INNER NOSE
CPT SUBSECTION: OTHER PROCEDURES		
30903	2	CONTROL OF NOSEBLEED
30905	2	CONTROL OF NOSEBLEED
30906	2	REPEAT CONTROL OF NOSEBLEED
30915	4	LIGATION, NASAL SINUS ARTERY
30920	5	LIGATION, UPPER JAW ARTERY
30930	6	THERAPY FRACTURE OF NOSE
ACCESSORY SINUSES		
CPT SUBSECTION: INCISION		
31020	4	EXPLORATION, MAXILLARY SINUS
31030	5	EXPLORATION, MAXILLARY SINUS
31032	6	EXPLORE SINUS,REMOVE POLYPS
31050	4	EXPLORATION, SPHENOID SINUS
31051	6	SPHENOID SINUS SURGERY
31070	4	EXPLORATION OF FRONTAL SINUS
31075	6	EXPLORATION OF FRONTAL SINUS
31080	6	REMOVAL OF FRONTAL SINUS

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RESPIRATORY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
31081	6	REMOVAL OF FRONTAL SINUS
31084	6	REMOVAL OF FRONTAL SINUS
31085	6	REMOVAL OF FRONTAL SINUS
31086	6	REMOVAL OF FRONTAL SINUS
31087	6	REMOVAL OF FRONTAL SINUS
31090	7	EXPLORATION OF SINUSES
CPT SUBSECTION: EXCISION		
31200	4	REMOVAL OF ETHMOID SINUS
31201	7	REMOVAL OF ETHMOID SINUS
31205	5	REMOVAL OF ETHMOID SINUS
CPT SUBSECTION: ENDOSCOPY		
31233	4	NASAL/SINUS ENDOSCOPY, DX
31235	2	NASAL/SINUS ENDOSCOPY, DX
31237	4	NASAL/SINUS ENDOSCOPY, SURG
31238	2	NASAL/SINUS ENDOSCOPY, SURG
31239	6	NASAL/SINUS ENDOSCOPY, SURG
31240	4	NASAL/SINUS ENDOSCOPY, SURG
31254	9	REVISION OF ETHMOID SINUS
31255	9	REMOVAL OF ETHMOID SINUS
31256	5	EXPLORATION MAXILLARY SINUS
31267	5	ENDOSCOPY, MAXILLARY SINUS
31276	5	SINUS ENDOSCOPY, SURGICAL
31287	5	NASAL/SINUS ENDOSCOPY, SURG
31288	5	NASAL/SINUS ENDOSCOPY, SURG
LARYNX		
CPT SUBSECTION: EXCISION		
31300	7	REMOVAL OF LARYNX LESION
31320	4	DIAGNOSTIC INCISION, LARYNX
31400	4	REVISION OF LARYNX
31420	4	REMOVAL OF EPIGLOTTIS
CPT SUBSECTION: ENDOSCOPY		
31510	4	LARYNGOSCOPY WITH BIOPSY
31511	4	REMOVE FOREIGN BODY, LARYNX
31512	4	REMOVAL OF LARYNX LESION
31513	4	INJECTION INTO VOCAL CORD
31515	2	LARYNGOSCOPY FOR ASPIRATION
31525	2	DIAGNOSTIC LARYNGOSCOPY
31526	4	DIAGNOSTIC LARYNGOSCOPY
31527	2	LARYNGOSCOPY FOR TREATMENT
31528	4	LARYNGOSCOPY AND DILATION
31529	4	LARYNGOSCOPY AND DILATION
31530	4	OPERATIVE LARYNGOSCOPY
31531	5	OPERATIVE LARYNGOSCOPY
31535	4	OPERATIVE LARYNGOSCOPY
31536	5	OPERATIVE LARYNGOSCOPY
31540	5	OPERATIVE LARYNGOSCOPY

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RESPIRATORY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
31541	7	OPERATIVE LARYNGOSCOPY
31545 ³	6	REMOVE VC LESION W/SCOPE
31546 ³	6	REMOVE VC LESION SCOPE/GRAFT
31560	7	OPERATIVE LARYNGOSCOPY
31561	7	OPERATIVE LARYNGOSCOPY
31570	4	LARYNGOSCOPY WITH INJECTION
31571	4	LARYNGOSCOPY WITH INJECTION
31576	4	LARYNGOSCOPY WITH BIOPSY
31577	4	REMOVE FOREIGN BODY, LARYNX
31578	4	REMOVAL OF LARYNX LESION
31580	7	REVISION OF LARYNX
31582	7	REVISION OF LARYNX
31585 ⁶	2	TREAT LARYNX FRACTURE
31586 ⁶	4	TREAT LARYNX FRACTURE
31588	7	REVISION OF LARYNX
31590	7	REINNERVATE LARYNX
CPT SUBSECTION: DESTRUCTION		
31595	4	LARYNX NERVE SURGERY
TRACHEA AND BRONCHI		
CPT SUBSECTION: INCISION		
31603 ³	2	INCISION OF WINDPIPE
31611	5	SURGERY/SPEECH PROSTHESIS
31612	2	PUNCTURE/CLEAR WINDPIPE
31613	4	REPAIR WINDPIPE OPENING
31614	4	REPAIR WINDPIPE OPENING
CPT SUBSECTION: ENDOSCOPY		
31615	2	VISUALIZATION OF WINDPIPE
31620 ⁷	2	ENDOBONCHIAL US ADD-ON
31622	3	DX BRONCHOSCOPE/WASH
31623	4	DX BRONCHOSCOPE/BRUSH
31624	4	DX BRONCHOSCOPE/LAVAGE
31625	4	BRONCHOSCOPY WITH BIOPSY
31628	3	BRONCHOSCOPY WITH BIOPSY
31629	4	BRONCHOSCOPY WITH BIOPSY
31630	4	BRONCHOSCOPY WITH REPAIR
31631	4	BRONCHOSCOPY WITH DILATION
31635	4	REMOVE FOREIGN BODY, AIRWAY
31636 ³	4	BRONCHOSCOPY, BRONCH STENTS
31637 ³	2	BRONCHOSCOPY, STENT ADD-ON
31638 ³	4	BRONCHOSCOPY, REVISE STENT
31640	4	BRONCHOSCOPY & REMOVE LESION
31641	4	BRONCHOSCOPY, TREAT BLOCKAGE
31643	4	DIAG BRONCHOSCOPE/CATHETER
31645	2	BRONCHOSCOPY, CLEAR AIRWAYS
31646	2	BRONCHOSCOPY, RECLEAR AIRWAY
31656	2	BRONCHOSCOPY, INJ FOR XRAY

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RESPIRATORY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: INTRODUCTION		
31700 ⁸	2	INSERTION OF AIRWAY CATHETER
31717	2	BRONCHIAL BRUSH BIOPSY
31720	2	CLEARANCE OF AIRWAYS
31730	2	INTRO, WINDPIPE WIRE/TUBE
CPT SUBSECTION: REPAIR		
31750	7	REPAIR OF WINDPIPE
31755	4	REPAIR OF WINDPIPE
CPT SUBSECTION: SUTURE		
31820	2	CLOSURE OF WINDPIPE LESION
31825	4	REPAIR OF WINDPIPE DEFECT
31830	4	REVISE WINDPIPE SCAR
LUNGS AND PLEURA		
CPT SUBSECTION: INCISION		
32000	1	DRAINAGE OF CHEST
CPT SUBSECTION: EXCISION		
32400	2	NEEDLE BIOPSY CHEST LINING
32405	1	BIOPSY, LUNG OR MEDIASTINUM
32420	2	PUNCTURE/CLEAR LUNG

CARDIOVASCULAR SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
HEART AND PERICARDIUM		
CPT SUBSECTION: PERICARDIUM		
33010	4	DRAINAGE OF HEART SAC
33011	4	REPEAT DRAINAGE OF HEART SAC
CPT SUBSECTION: PACEMAKER OR PACING CARDIOVERTER-DEFIBRILLATOR		
33212 ³	5	INSERTION OF PULSE GENERATOR
33213 ³	5	INSERTION OF PULSE GENERATOR
33222	4	REVISE POCKET, PACEMAKER
33223	4	REVISE POCKET, PACING-DEFIB
33233 ³	4	REMOVAL OF PACEMAKER SYSTEM
ARTERIES AND VEINS		
CPT SUBSECTION: REPAIR ARTERIOVENOUS FISTULA		
35188	6	REPAIR BLOOD VESSEL LESION
CPT SUBSECTION: REPAIR BLOOD VESSEL OTHER THAN FOR FISTULA, WITH OR WITHOUT PATCH ANGIOPLASTY		
35207	6	REPAIR BLOOD VESSEL LESION
CPT SUBSECTION: EXPLORATION/REVISION		
35875	10	REMOVAL OF CLOT IN GRAFT
35876	10	REMOVAL OF CLOT IN GRAFT
CPT SUBSECTION: INTRA-ARTERIAL-INTRA-AORTIC		
36260	5	INSERTION OF INFUSION PUMP

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CARDIOVASCULAR SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
36261	4	REVISION OF INFUSION PUMP
36262	2	REMOVAL OF INFUSION PUMP
CPT SUBSECTION: VENOUS		
36475 ³	10	ENDOVENOUS RF, 1ST VEIN
36476 ³	10	ENDOVENOUS RF, VEIN ADD-ON
36478 ³	10	ENDOVENOUS LASER, 1ST VEIN
36479 ³	10	ENDOVENOUS LASER VEIN ADDON
36488 ²	2	INSERTION OF CATHETER, VEIN
36489 ²	2	INSERTION OF CATHETER, VEIN
36490 ²	2	INSERTION OF CATHETER, VEIN
36491 ²	2	INSERTION OF CATHETER, VEIN
36530 ²	5	INSERTION OF INFUSION PUMP
36531 ²	4	REVISION OF INFUSION PUMP
36532 ²	2	REMOVAL OF INFUSION PUMP
36533 ²	6	INSERTION OF ACCESS DEVICE
36534 ²	4	REVISION OF ACCESS DEVICE
36535 ²	3	REMOVAL OF ACCESS DEVICE
36555 ¹	2	INSERT NON-TUNNELED CV CATH
36556 ¹	2	INSERT NON-TUNNELED CV CATH
36557 ¹	5	INSERT TUNNELED CV CATH
36558 ¹	5	INSERT TUNNELED CV CATH
36560 ¹	6	INSERT TUNNELED CV CATH
36561 ¹	6	INSERT TUNNELED CV CATH
36563 ¹	6	INSERT TUNNELED CV CATH
36565 ¹	6	INSERT TUNNELED CV CATH
36566 ¹	6	INSERT TUNNELED CV CATH
36566 ¹	6	INSERT TUNNELED CV CATH
36568 ¹	2	INSERT TUNNELED CV CATH
36569 ¹	2	INSERT TUNNELED CV CATH
36570 ¹	6	INSERT TUNNELED CV CATH
36571 ¹	6	INSERT TUNNELED CV CATH
36575 ¹	4	REPAIR TUNNELED CV CATH
36576 ¹	4	REPAIR TUNNELED CV CATH
36578 ¹	4	REPLACE TUNNELED CV CATH
36580 ¹	2	REPLACE TUNNELED CV CATH
36581 ¹	4	REPLACE TUNNELED CV CATH
36582 ¹	5	REPLACE TUNNELED CV CATH
36583 ¹	5	REPLACE TUNNELED CV CATH
36584 ¹	2	REPLACE TUNNELED CV CATH
36585 ¹	5	REPLACE TUNNELED CV CATH
36589 ¹	2	REMOVAL TUNNELED CV CATH
36590 ¹	2	REMOVAL TUNNELED CV CATH
CPT SUBSECTION: ARTERIAL		
36640	2	INSERTION CATHETER, ARTERY
CPT SUBSECTION: INTERVASCULAR CANNULIZATION OR SHUNT (SEPARATE PROCEDURE)		
36800	5	INSERTION OF CANNULA
36810	5	INSERTION OF CANNULA

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CARDIOVASCULAR SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
36815	5	INSERTION OF CANNULA
36818 ⁷	5	AV FUSE, UPPR ARM, CEPHALIC
36819	5	AV FUSION/UPPR ARM VEIN
36820	5	AV FUSION/FOREARM VEIN
36821	5	AV FUSION DIRECT ANY SITE
36825	6	ARTERY-VEIN GRAFT
36830	6	ARTERY-VEIN GRAFT
36831	10	OPEN THROMBECT AV FISTULA
36832	6	AV FISTULA REVISION, OPEN
36833	6	AV FISTULA REVISION
36834 ³	5	REPAIR A-V ANEURYSM
36835	6	ARTERY TO VEIN SHUNT
36860	4	EXTERNAL CANNULA DECLOTTING
36861	5	CANNULA DECLOTTING
36870	10	PERCUT THROMBECT AV FISTULA

CPT SUBSECTION: LIGATION AND OTHER PROCEDURES

37500 ³	5	ENDOSCOPY LIGATE PERF VEINS
37607	5	LIGATION OF A-V FISTULA
37609	4	TEMPORAL ARTERY PROCEDURE
37650	4	REVISION OF MAJOR VEIN
37700	4	REVISE LEG VEIN
37718 ⁵	5	LIGATE/STRIP SHORT LEG VEIN
37720 ⁶	9	REMOVAL OF LEG VEIN
37722 ⁵	5	LIGATE/STRIP LONG LEG VEIN
37730 ⁶	5	REMOVAL OF LEG VEINS
37735	5	REMOVAL OF LEG VEINS/LESION
37760	5	REVISION OF LEG VEINS
37780	5	REVISION OF LEG VEIN
37785	5	REVISE SECONDARY VARICOSITY
37790	5	PENILE VENOUS OCCLUSION

HEMIC AND LYMPHATIC SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
NODES AND LYMPHATIC CHANNELS		
CPT SUBSECTION: INCISION		
38300	2	DRAINAGE, LYMPH NODE LESION
38305	4	DRAINAGE, LYMPH NODE LESION
38308	4	INCISION OF LYMPH CHANNELS
CPT SUBSECTION: EXCISION		
38500	6	BIOPSY/REMOVAL, LYMPH NODES
38505	2	NEEDLE BIOPSY, LYMPH NODES
38510	8	BIOPSY/REMOVAL, LYMPH NODES
38520	4	BIOPSY/REMOVAL, LYMPH NODES
38525	7	BIOPSY/REMOVAL, LYMPH NODES
38530	4	BIOPSY/REMOVAL, LYMPH NODES

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HEMIC AND LYMPHATIC SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
38542	4	EXPLORE DEEP NODE(S), NECK
38550	5	REMOVAL, NECK/ARMPIT LESION
38555	6	REMOVAL, NECK/ARMPIT LESION
CPT SUBSECTION: LAPAROSCOPY		
38570	10	LAPAROSCOPY, LYMPH NODE BIOP
38571	10	LAPAROSCOPY, LYMPHADENECTOMY
38572	10	LAPAROSCOPY, LYMPHADENECTOMY
CPT SUBSECTION: RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)		
38740	4	REMOVE ARMPIT LYMPH NODES
38745	6	REMOVE ARMPIT LYMPH NODES
38760	4	REMOVE GROIN LYMPH NODES

DIGESTIVE SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
LIPS		
CPT SUBSECTION: EXCISION		
40500	4	PARTIAL EXCISION OF LIP
40510	4	PARTIAL EXCISION OF LIP
40520	4	PARTIAL EXCISION OF LIP
40525	4	RECONSTRUCT LIP WITH FLAP
40527	4	RECONSTRUCT LIP WITH FLAP
40530	4	PARTIAL REMOVAL OF LIP
CPT SUBSECTION: REPAIR (CHEILOPLASTY)		
40650	5	REPAIR LIP
40652	5	REPAIR LIP
40654	5	REPAIR LIP
40700	9	REPAIR CLEFT LIP/NASAL
40701	9	REPAIR CLEFT LIP/NASAL
40720	9	REPAIR CLEFT LIP/NASAL
40761	5	REPAIR CLEFT LIP/NASAL
VESTIBULE OF MOUTH		
CPT SUBSECTION: INCISION		
40801	4	DRAINAGE OF MOUTH LESION
CPT SUBSECTION: EXCISION, DESTRUCTION		
40814	4	EXCISE/REPAIR MOUTH LESION
40816	4	EXCISION OF MOUTH LESION
40818	2	EXCISE ORAL MUCOSA FOR GRAFT
40819	2	EXCISE LIP OR CHEEK FOLD
CPT SUBSECTION: REPAIR		
40831	2	REPAIR MOUTH LACERATION
40840	4	RECONSTRUCTION OF MOUTH
40842	5	RECONSTRUCTION OF MOUTH
40843	5	RECONSTRUCTION OF MOUTH

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
40844	7	RECONSTRUCTION OF MOUTH
40845	7	RECONSTRUCTION OF MOUTH
TONGUE, FLOOR OF MOUTH		
CPT SUBSECTION: INCISION		
41005	2	DRAINAGE OF MOUTH LESION
41006	2	DRAINAGE OF MOUTH LESION
41007	2	DRAINAGE OF MOUTH LESION
41008	2	DRAINAGE OF MOUTH LESION
41009	2	DRAINAGE OF MOUTH LESION
41010	2	INCISION OF TONGUE FOLD
41015	2	DRAINAGE OF MOUTH LESION
41016	2	DRAINAGE OF MOUTH LESION
41017	2	DRAINAGE OF MOUTH LESION
41018	2	DRAINAGE OF MOUTH LESION
CPT SUBSECTION: EXCISION		
41112	4	EXCISION OF TONGUE LESION
41113	4	EXCISION OF TONGUE LESION
41114	4	EXCISION OF TONGUE LESION
41116	2	EXCISION OF MOUTH LESION
41120	7	PARTIAL REMOVAL OF TONGUE
CPT SUBSECTION: REPAIR		
41250	4	REPAIR TONGUE LACERATION
41251	4	REPAIR TONGUE LACERATION
41252	4	REPAIR TONGUE LACERATION
CPT SUBSECTION: OTHER PROCEDURES		
41500	2	FIXATION OF TONGUE
41510	2	TONGUE TO LIP SURGERY
41520	4	RECONSTRUCTION, TONGUE FOLD
DENTOALVEOLAR STRUCTURES		
CPT SUBSECTION: INCISION		
41800	2	DRAINAGE OF GUM LESION
CPT SUBSECTION: EXCISION, DESTRUCTION		
41827	4	EXCISION OF GUM LESION
PALATE, UVULA		
CPT SUBSECTION: INCISION		
42000	4	DRAINAGE MOUTH ROOF LESION
CPT SUBSECTION: EXCISION, DESTRUCTION		
42107	4	EXCISION LESION, MOUTH ROOF
42120	6	REMOVE PALATE/LESION
42140	4	EXCISION OF UVULA
42145	9	REPAIR PALATE, PHARYNX/UVULA
CPT SUBSECTION: REPAIR		
42180	2	REPAIR PALATE
42182	4	REPAIR PALATE
42200	7	RECONSTRUCT CLEFT PALATE

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
42205	7	RECONSTRUCT CLEFT PALATE
42210	7	RECONSTRUCT CLEFT PALATE
42215	9	RECONSTRUCT CLEFT PALATE
42220	7	RECONSTRUCT CLEFT PALATE
42226	7	LENGTHENING OF PALATE
42235	7	REPAIR PALATE
42260	6	REPAIR NOSE TO LIP FISTULA
SALIVARY GLAND AND DUCTS		
CPT SUBSECTION: INCISION		
42300	2	DRAINAGE OF SALIVARY GLAND
42305	4	DRAINAGE OF SALIVARY GLAND
42310	2	DRAINAGE OF SALIVARY GLAND
42320	2	DRAINAGE OF SALIVARY GLAND
42325 ⁶	4	CREATE SALIVARY CYST DRAIN
42340	4	REMOVAL OF SALIVARY STONE
CPT SUBSECTION: EXCISION		
42405	4	BIOPSY OF SALIVARY GLAND
42408	5	EXCISION OF SALIVARY CYST
42409	5	DRAINAGE OF SALIVARY CYST
42410	5	EXCISE PAROTID GLAND/LESION
42415	9	EXCISE PAROTID GLAND/LESION
42420	9	EXCISE PAROTID GLAND/LESION
42425	9	EXCISE PAROTID GLAND/LESION
42440	5	EXCISE SUBMAXILLARY GLAND
42450	4	EXCISE SUBLINGUAL GLAND
CPT SUBSECTION: REPAIR		
42500	5	REPAIR SALIVARY DUCT
42505	6	REPAIR SALIVARY DUCT
42507	5	PAROTID DUCT DIVERSION
42508	6	PAROTID DUCT DIVERSION
42509	6	PAROTID DUCT DIVERSION
42510	6	PAROTID DUCT DIVERSION
CPT SUBSECTION: OTHER PROCEDURES		
42600	2	CLOSURE OF SALIVARY FISTULA
42665 ³	9	LIGATION OF SALIVARY DUCT
PHARYNX, ADENOIDS, AND TONSILS		
CPT SUBSECTION: INCISION		
42700	2	DRAINAGE OF TONSIL ABSCESS
42720	2	DRAINAGE OF THROAT ABSCESS
42725	4	DRAINAGE OF THROAT ABSCESS
CPT SUBSECTION: EXCISION, DESTRUCTION		
42802	2	BIOPSY OF THROAT
42804	2	BIOPSY OF UPPER NOSE/THROAT
42806	4	BIOPSY OF UPPER NOSE/THROAT
42808	4	EXCISE PHARYNX LESION
42810	5	EXCISION OF NECK CYST

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
42815	7	EXCISION OF NECK CYST
42820	6	REMOVE TONSILS AND ADENOIDS
42821	7	REMOVE TONSILS AND ADENOIDS
42825	7	REMOVAL OF TONSILS
42826	7	REMOVAL OF TONSILS
42830	5	REMOVAL OF ADENOIDS
42831	6	REMOVAL OF ADENOIDS
42835	6	REMOVAL OF ADENOIDS
42836	6	REMOVAL OF ADENOIDS
42860	5	EXCISION OF TONSIL TAGS
42870	5	EXCISION OF LINGUAL TONSIL
42890	9	PARTIAL REMOVAL OF PHARYNX
42892	9	REVISION OF PHARYNGEAL WALLS
CPT SUBSECTION: REPAIR		
42900	2	REPAIR THROAT WOUND
42950	4	RECONSTRUCTION OF THROAT
CPT SUBSECTION: OTHER PROCEDURES		
42955	4	SURGICAL OPENING OF THROAT
42960	2	CONTROL THROAT BLEEDING
42962	4	CONTROL THROAT BLEEDING
42972	5	CONTROL NOSE/THROAT BLEEDING
ESOPHAGUS		
CPT SUBSECTION: ENDOSCOPY		
43200	2	ESOPHAGUS ENDOSCOPY
43201	2	ESOPH SCOPE W/ SUBMUCOUS INJ
43202	2	ESOPHAGUS ENDOSCOPY, BIOPSY
43204	2	ESOPHAGUS ENDOSCOPY & INJECT
43205	2	ESOPHAGUS ENDOSCOPY/LIGATION
43215	2	ESOPHAGUS ENDOSCOPY
43216	2	ESOPHAGUS ENDOSCOPY/LESION
43217	2	ESOPHAGUS ENDOSCOPY
43219	2	ESOPHAGUS ENDOSCOPY
43220	2	ESOPH ENDOSCOPY, DILATION
43226	2	ESOPH ENDOSCOPY, DILATION
43227	4	ESOPH ENDOSCOPY, REPAIR
43228	4	ESOPH ENDOSCOPY, ABLATION
43231	4	ESOPH ENDOSCOPY W/ US EXAM
43232	4	ESOPH ENDOSCOPY W/ US FN BX
43234	2	UPPER GI ENDOSCOPY, EXAM
43235	2	UPPR GI ENDOSCOPY, DIAGNOSIS
43236	4	UPPR GI SCOPY W/ SUBMUC INJ
43237 ³	4	ENDOSCOPIC US EXAM, ESOPH
43238 ³	4	UPPR GI ENDOSCOPY W/US FN BX
43239	3	UPPER GI ENDOSCOPY, BIOPSY
43240	4	ESOPH ENDOSCOPE W/ DRAIN CYST
43241	4	UPPER GI ENDOSCOPY WITH TUBE
43242	4	UPPR GI ENDOSCOPY W/ US FN BX

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
43243	4	UPPER GI ENDOSCOPY & INJECT
43244	4	UPPER GI ENDOSCOPY/LIGATION
43245	4	OPERATIVE UPPER GI ENDOSCOPY
43246	4	PLACE GASTROSTOMY TUBE
43247	3	OPERATIVE UPPER GI ENDOSCOPY
43248	3	UPPR GI ENDOSCOPY/GUIDE WIRE
43249	3	ESOPH ENDOSCOPY, DILATION
43250	3	UPPER GI ENDOSCOPY/TUMOR
43251	3	OPERATIVE UPPER GI ENDOSCOPY
43255	4	OPERATIVE UPPER GI ENDOSCOPY
43256	5	UPPR GI ENDOSCOPY W STENT
43257 ⁷	5	UPPR GI SCOPE W/THRML TXMNT
43258	5	OPERATIVE UPPER GI ENDOSCOPY
43259	4	ENDOSCOPIC ULTRASOUND EXAM
43260	5	ENDO CHOLANGIOPANCREATOGRAPH
43261	4	ENDO CHOLANGIOPANCREATOGRAPH
43262	4	ENDO CHOLANGIOPANCREATOGRAPH
43263	4	ENDO CHOLANGIOPANCREATOGRAPH
43264	4	ENDO CHOLANGIOPANCREATOGRAPH
43265	4	ENDO CHOLANGIOPANCREATOGRAPH
43267	4	ENDO CHOLANGIOPANCREATOGRAPH
43268	4	ENDO CHOLANGIOPANCREATOGRAPH
43269	4	ENDO CHOLANGIOPANCREATOGRAPH
43271	4	ENDO CHOLANGIOPANCREATOGRAPH
43272	4	ENDO CHOLANGIOPANCREATOGRAPH
CPT SUBSECTION: MANIPULATION		
43450	3	DILATE ESOPHAGUS
43453	2	DILATE ESOPHAGUS
43456	4	DILATE ESOPHAGUS
43458	4	DILATE ESOPHAGUS
STOMACH		
CPT SUBSECTION: EXCISION		
43600	2	BIOPSY OF STOMACH
CPT SUBSECTION: LAPAROSCOPY		
43653	10	LAPAROSCOPY, GASTROSTOMY
CPT SUBSECTION: INTRODUCTION		
43750	4	PLACE GASTROSTOMY TUBE
43760	1	CHANGE GASTROSTOMY TUBE
43761 ⁷	2	REPOSITION GASTROSTOMY TUBE
CPT SUBSECTION: SUTURE		
43870	2	REPAIR STOMACH OPENING
INTESTINES (EXCEPT RECTUM)		
CPT SUBSECTION: EXCISION		
44100	2	BIOPSY OF BOWEL

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES		
44312	2	REVISION OF ILEOSTOMY
44340	5	REVISION OF COLOSTOMY
CPT SUBSECTION: ENDOSCOPY, SMALL BOWEL AND STOMAL		
44360	4	SMALL BOWEL ENDOSCOPY
44361	4	SMALL BOWEL ENDOSCOPY/BIOPSY
44363	4	SMALL BOWEL ENDOSCOPY
44364	4	SMALL BOWEL ENDOSCOPY
44365	4	SMALL BOWEL ENDOSCOPY
44366	4	SMALL BOWEL ENDOSCOPY
44369	4	SMALL BOWEL ENDOSCOPY
44370	10	SMALL BOWEL ENDOSCOPY/STENT
44372	4	SMALL BOWEL ENDOSCOPY
44373	4	SMALL BOWEL ENDOSCOPY
44376	4	SMALL BOWEL ENDOSCOPY
44377	4	SMALL BOWEL ENDOSCOPY/BIOPSY
44378	4	SMALL BOWEL ENDOSCOPY
44379	10	S BOWEL ENDOSCOPE W/ STENT
44380	2	SMALL BOWEL ENDOSCOPY
44382	2	SMALL BOWEL ENDOSCOPY
44383	10	ILEOSCOPY W/ STENT
44385	2	ILEOSCOPY W/STENT
44386	2	ENDOSCOPY, BOWEL POUCH/BIOP
44388	2	COLON ENDOSCOPY
44389	2	COLONOSCOPY WITH BIOPSY
44390	2	COLONOSCOPY FOR FOREIGN BODY
44391	2	COLONOSCOPY FOR BLEEDING
44392	2	COLONOSCOPY & POLYPECTOMY
44393	2	COLONOSCOPY, LESION REMOVAL
44394	2	COLONOSCOPY W/SNARE
44397 ³	2	COLONOSCOPY W/STENT
RECTUM		
CPT SUBSECTION: INCISION		
45000	2	DRAINAGE OF PELVIC ABSCESS
45005	4	DRAINAGE OF RECTAL ABSCESS
45020	4	DRAINAGE OF RECTAL ABSCESS
CPT SUBSECTION: EXCISION		
45100	2	BIOPSY OF RECTUM
45108	4	REMOVAL OF ANORECTAL LESION
45150	4	EXCISION OF RECTAL STRICTURE
45160	4	EXCISION OF RECTAL LESION
45170	4	EXCISION OF RECTAL LESION
CPT SUBSECTION: DESTRUCTION		
45190	10	DESTRUCTION, RECTAL TUMOR
CPT SUBSECTION: ENDOSCOPY		
45305	2	PROTOSIGMOIDOSCOPY W/BX

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
45307	2	PROTOSIGMOIDOSCOPY FB
45308	2	PROTOSIGMOIDOSCOPY REMOVAL
45309	2	PROTOSIGMOIDOSCOPY REMOVAL
45315	2	PROTOSIGMOIDOSCOPY REMOVAL
45317	2	PROTOSIGMOIDOSCOPY BLEED
45320	2	PROTOSIGMOIDOSCOPY ABLATE
45321	2	PROTOSIGMOIDOSCOPY VOLVUL
45327 ³	2	PROCTOSIGMOIDOSCOPY W/STENT
45331	1	SIGMOIDOSCOPY AND BIOPSY
45332	2	SIGMOIDOSCOPY W/FB REMOVAL
45333	2	SIGMOIDOSCOPY & POLYPECTOMY
45334	2	SIGMOIDOSCOPY FOR BLEEDING
45335	2	SIGMOIDOSCOPE W/SUBMUB INJ
45337	2	SIGMOIDOSCOPY & DECOMPRESS
45338	2	SIGMOIDOSCPY W/TUMR REMOVE
45339	2	SIGMOIDOSCOPY W/ABLATE TUMR
45340	2	SIG W/BALLOON DILATION
45341 ³	2	SIGMOIDOSCOPY W/ULTRASOUND
45342 ³	2	SIGMOIDOSCOPY W/US GUIDE BX
45345 ³	2	SIGMOIDOSCOPY W/STENT
45355	2	SURGICAL COLONOSCOPY
45378	3	DIAGNOSTIC COLONOSCOPY
45379	4	COLONOSCOPY W/FB REMOVAL
45380	4	COLONOSCOPY AND BIOPSY
45381	4	COLONOSCOPE, SUBMUCOUS INJ
45382	4	COLONOSCOPY/CONTROL BLEEDING
45383	4	LESION REMOVAL COLONOSCOPY
45384	4	LESION REMOVE COLONOSCOPY
45385	4	LESION REMOVAL COLONOSCOPY
45386	4	COLONOSCOPE DILATE STRICTURE
45387 ³	2	COLONOSCOPY W/STENT
45391 ³	4	COLONOSCOPY W/ENDOSCOPE US
45392 ³	4	COLONOSCOPY W/ENDOSCOPIC FNB
CPT SUBSECTION: REPAIR		
45500	4	REPAIR OF RECTUM
45505	4	REPAIR OF RECTUM
45560	4	REPAIR OF RECTOCELE
CPT SUBSECTION: MANIPULATION		
45900	2	REDUCTION OF RECTAL PROLAPSE
45905	2	DILATION OF ANAL SPHINCTER
45910	2	DILATION OF RECTAL NARROWING
45915	2	REMOVE RECTAL OBSTRUCTION
45990 ⁵	4	SURG DX EXAM, ANORECTAL
ANUS		
CPT SUBSECTION: INCISION		
46020	5	PLACEMENT OF SETON
46030	2	REMOVAL OF RECTAL MARKER

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
46040	5	INCISION OF RECTAL ABSCESS
46045	4	INCISION OF RECTAL ABSCESS
46050	2	INCISION OF ANAL ABSCESS
46060	4	INCISION OF RECTAL ABSCESS
46080	5	INCISION OF ANAL SPHINCTER
CPT SUBSECTION: EXCISION		
46200	4	REMOVAL OF ANAL FISSURE
46210	4	REMOVAL OF ANAL CRYPT
46211	4	REMOVAL OF ANAL CRYPTS
46220	2	REMOVAL OF ANAL TAB
46230 ³	2	REMOVAL OF ANAL TAGS
46250	5	HEMORRHOIDECTOMY
46255	7	HEMORRHOIDECTOMY
46257	5	REMOVE HEMORRHOIDS & FISSURE
46258	5	REMOVE HEMORRHOIDS & FISTULA
46260	9	HEMORRHOIDECTOMY
46261	6	REMOVE HEMORRHOIDS & FISSURE
46262	6	REMOVE HEMORRHOIDS & FISTULA
46270	7	REMOVAL OF ANAL FISTULA
46275	5	REMOVAL OF ANAL FISTULA
46280	6	REMOVAL OF ANAL FISTULA
46285	2	REMOVAL OF ANAL FISTULA
46288	6	REPAIR ANAL FISTULA
CPT SUBSECTION: ENDOSCOPY		
46608	2	ANOSCOPY/ REMOVE FOR BODY
46610	2	ANOSCOPY/REMOVE LESION
46611	2	ANOSCOPY
46612	2	ANOSCOPY/ REMOVE LESIONS
46615	4	ANOSCOPY
CPT SUBSECTION: REPAIR		
46700	5	REPAIR OF ANAL STRICTURE
46706 ³	2	REPR OF ANAL FISTULA W/GLUE
46750	5	REPAIR OF ANAL SPHINCTER
46753	5	RECONSTRUCTION OF ANUS
46754	4	REMOVAL OF SUTURE FROM ANUS
46760	4	REPAIR OF ANAL SPHINCTER
46761	5	REPAIR OF ANAL SPHINCTER
46762	9	IMPLANT ARTIFICIAL SPHINCTER
CPT SUBSECTION: DESTRUCTION		
46917	2	LASER SURGERY, ANAL LESIONS
CPT SUBSECTION: DESTRUCTION		
46922	2	EXCISION OF ANAL LESION(S)
46924	2	DESTRUCTION, ANAL LESION(S)
46937	4	CRYOTHERAPY OF RECTAL LESION
46938	4	CRYOTHERAPY OF RECTAL LESION

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TRICARE-APPROVED AMBULATORY SURGERY PROCEDURES ON OR AFTER 11/01/2003

DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: SUTURE		
46946 ⁷	2	LIGATION OF HEMORRHOIDS
46947 ³	9	HEMORRHOIDOPEXY BY STAPLING
LIVER		
CPT SUBSECTION: INCISION		
47000	1	NEEDLE BIOPSY OF LIVER
49402 ⁷	4	REMOVE FOREIGN BODY, ADBOMEN
BILIARY TRACT		
CPT SUBSECTION: INTRODUCTION		
47510	4	INSERT CATHETER, BILE DUCT
47511	10	INSERT BILE DUCT DRAIN
47525	2	CHANGE BILE DUCT CATHETER
47530	2	REVISE/REINSERT BILE TUBE
CPT SUBSECTION: ENDOSCOPY		
47552	4	BILIARY ENDOSCOPY THRU SKIN
47553	5	BILIARY ENDOSCOPY THRU SKIN
47554	5	BILIARY ENDOSCOPY THRU SKIN
47555	5	BILIARY ENDOSCOPY THRU SKIN
47556	10	BILIARY ENDOSCOPY THRU SKIN
CPT SUBSECTION: LAPAROSCOPY		
47560	5	LAPAROSCOPY W/CHOLANGIO
47561	5	LAPARO W/CHOLANGIO/BIOPSY
CPT SUBSECTION: EXCISION		
47630	5	REMOVE BILE DUCT STONE
PANCREAS		
CPT SUBSECTION: EXCISION		
48102	2	NEEDLE BIOPSY, PANCREAS
ABDOMEN, PERITONEUM, AND OMENTUM		
CPT SUBSECTION: INCISION		
49080	1	PUNCTURE, PERITONEAL CAVITY
49081	4	REMOVAL OF ABDOMINAL FLUID
49085 ⁸	4	REMOVE ABDOMEN FOREIGN BODY
CPT SUBSECTION: EXCISION AND DESTRUCTION		
49180	2	BIOPSY, ABDOMINAL MASS
49250	6	EXCISION OF UMBILICUS
CPT SUBSECTION: LAPAROSCOPY		
49320	8	DIAG LAPARO SEPARATE PROC
49321	6	LAPAROSCOPY, BIOPSY
49322	9	LAPAROSCOPY, ASPIRATION
CPT SUBSECTION: INTRODUCTION AND REVISION		
49419 ³	2	INSRT ABDOM CATH FOR CHEMOTX
49420	2	INSERT ABDOMINAL DRAIN
49421	2	INSERT ABDOMINAL DRAIN
49422	2	REMOVE PERM CANNULA/CATHETER

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DIGESTIVE SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
49426	4	REVISE ABDOMEN-VENOUS SHUNT
CPT SUBSECTION: HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY		
49495	6	RPR ING HERNIA BABY, REDUC
49496	6	RPR ING HERNIA BABY, BLOCKED
49500	7	RPR ING HERNIA, INIT, REDUCE
49501	10	RPR ING HERNIA, INIT BLOCKED
49505	9	RPR I/HERN INIT REDUC > 5 YR
49507	10	RPR I/HERN INIT BLOCK > 5 YR
49520	9	REREPAIR ING HERNIA, REDUCE
49521	10	REREPAIR ING HERNIA, BLOCKED
49525	6	REPAIR ING HERNIA, SLIDING
49540	4	REPAIR LUMBAR HERNIA
49550	7	RPR FEM HERNIA, INIT, REDUCE
49553	10	RPR FEM HERNIA, INIT BLOCKED
49555	7	REREPAIR FEM HERNIA, REDUCE
49557	10	REREPAIR FEM HERNIA, BLOCKED
49560	9	RPR VENTRAL HERN INIT, REDUC
49561	10	RPR VENTRAL HERN INIT, BLOCK
49565	6	REREPAIR VENTRL HERN, REDUCE
49566	10	REREPAIR VENTRL HERN, BLOCK
49568	9	HERNIA REPAIR W/MESH
49570	6	RPR EPIGASTRIC HERN, REDUCE
49572	10	RPR EPIGASTRIC HERN, BLOCK
49580	6	RPR UMBIL HERN, REDUC < 5 YR
49582	10	RPR UMBIL HERN, BLOCK < 5 YR
49585	8	RPR UMBIL HERN, REDUC > 5 YR
49587	10	RPR UMBIL HERN, BLOCK > 5 YR
49590	5	REPAIR SPIGELIAN HERNIA
49600	6	REPAIR UMBILICAL LESION
CPT SUBSECTION: LAPAROSCOPY		
49650	10	LAPARO HERNIA REPAIR INITIAL
49651	9	LAPARO HERNIA REPAIR RECUR

URINARY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
KIDNEY		
CPT SUBSECTION: EXCISION		
50200	2	BIOPSY OF KIDNEY
CPT SUBSECTION: INTRODUCTION		
50390	2	DRAINAGE OF KIDNEY LESION
50392	2	INSERT KIDNEY DRAIN
50393	2	INSERT URETERAL TUBE
50395	2	CREATE PASSAGE TO KIDNEY
50396	2	MEASURE KIDNEY PRESSURE
50398	2	CHANGE KIDNEY TUBE

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URINARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: ENDOSCOPY		
50551	2	KIDNEY ENDOSCOPY
50553	2	KIDNEY ENDOSCOPY
50555	2	KIDNEY ENDOSCOPY & BIOPSY
50557	2	KIDNEY ENDOSCOPY & TREATMENT
50559 ⁴	2	RENAL ENDOSCOPY/RADIOTRACER
50561	2	KIDNEY ENDOSCOPY & TREATMENT
CPT SUBSECTION: OTHER PROCEDURES		
50590	11	FRAGMENTING OF KIDNEY STONE
URETER		
CPT SUBSECTION: INTRODUCTION		
50688	2	CHANGE OF URETER TUBE
CPT SUBSECTION: LAPAROSCOPY		
50947	10	LAPARO NEW URETER/BLADDER
50948	10	LAPARO NEW URETER/BLADDER
CPT SUBSECTION: ENDOSCOPY		
50951	2	ENDOSCOPY OF URETER
50953	2	ENDOSCOPY OF URETER
50955	2	URETER ENDOSCOPY & BIOPSY
50957	2	URETER ENDOSCOPY & TREATMENT
50959 ⁴	2	URETER ENDOSCOPY & TRACER
50961	2	URETER ENDOSCOPY & TREATMENT
50970	2	URETER ENDOSCOPY
50972	2	URETER ENDOSCOPY & CATHETER
50974	2	URETER ENDOSCOPY & BIOPSY
50976	2	URETER ENDOSCOPY & TREATMENT
50978 ⁴	2	URETER ENDOSCOPY & TRACER
50980	2	URETER ENDOSCOPY & TREATMENT
BLADDER		
CPT SUBSECTION: INCISION		
51010	2	DRAINAGE OF BLADDER
51020	6	INCISE & TREAT BLADDER
51030	6	INCISE & TREAT BLADDER
51040	6	INCISE & DRAIN BLADDER
51045	6	INCISE BLADDER/DRAIN URETER
51050	6	REMOVAL OF BLADDER STONE
51065	6	REMOVE URETER CALCULUS
51080	2	DRAINAGE OF BLADDER ABSCESS
CPT SUBSECTION: EXCISION		
51500	6	REMOVAL OF BLADDER CYST
51520	6	REMOVAL OF BLADDER LESION
CPT SUBSECTION: INTRODUCTION		
51710	2	CHANGE OF BLADDER TUBE
51715	5	ENDOSCOPIC INJECTION/IMPLANT

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URINARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: URODYNAMICS		
51726	1	COMPLEX CYSTOMETROGRAM
51772	2	URETHRA PRESSURE PROFILE
51785	2	ANAL/URINARY MUSCLE STUDY
51880	2	REPAIR OF BLADDER OPENING
51992 ³	7	LAPARO SLING OPERATION
CPT SUBSECTION: ENDOSCOPY-SYSTOSCOPY, URETHROSCOPY, CYSTOURETHROSCOPY		
52000	3	CYSTOSCOPY
52001	4	CYSTOSCOPY, REMOVAL OF CLOTS
52005	6	CYSTOSCOPY & URETER CATHETER
52007	4	CYSTOSCOPY AND BIOPSY
52010	4	CYSTOSCOPY & DUCT CATHETER
CPT SUBSECTION: TRANSURETHRAL SURGERY (URETHRA AND BLADDER)		
52204	5	CYSTOSCOPY
52214	5	CYSTOSCOPY AND TREATMENT
52224	4	CYSTOSCOPY AND TREATMENT
52234	6	CYSTOSCOPY AND TREATMENT
52235	5	CYSTOSCOPY AND TREATMENT
52240	5	CYSTOSCOPY AND TREATMENT
52250	6	CYSTOSCOPY AND RADIOTRACER
52260	5	CYSTOSCOPY AND TREATMENT
52270	4	CYSTOSCOPY & REVISE URETHRA
52275	4	CYSTOSCOPY & REVISE URETHRA
52276	5	CYSTOSCOPY AND TREATMENT
52277	4	CYSTOSCOPY AND TREATMENT
52281	5	CYSTOSCOPY AND TREATMENT
52282	10	CYSTOSCOPY, IMPLANT STENT
52283	4	CYSTOSCOPY AND TREATMENT
52285	4	CYSTOSCOPY AND TREATMENT
52290	4	CYSTOSCOPY AND TREATMENT
52300	4	CYSTOSCOPY AND TREATMENT
52301 ³	5	CYSTOSCOPY AND TREATMENT
52305	4	CYSTOSCOPY AND TREATMENT
52310	5	CYSTOSCOPY AND TREATMENT
52315	4	CYSTOSCOPY AND TREATMENT
52317	2	REMOVE BLADDER STONE
52318	4	REMOVE BLADDER STONE
CPT SUBSECTION: TRANSURETHRAL SURGERY (URETER AND PELVIS)		
52320	7	CYSTOSCOPY AND TREATMENT
52325	6	CYSTOSCOPY, STONE REMOVAL
52327	4	CYSTOSCOPY, INJECT MATERIAL
52330	4	CYSTOSCOPY AND TREATMENT
52332	6	CYSTOSCOPY AND TREATMENT
52334	5	CREATE PASSAGE TO KIDNEY
52341	5	CYSTO W/URETER STRICTURE TX
52342	5	CYSTO W/UP STRICTURE TX
52343	5	CYSTO W/RENAL STRICTURE TX

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URINARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
52344	5	CYSTO/URETERO, STONE REMOVE
52345	5	CYSTO/URETERO W/UP STRICTURE
52346	5	CYSTOURETERO W/RENAL STRICT
52351	5	CYSTOURETRO & OR PYELOSCOPE
52352	8	CYSTOURETRO W/STONE REMOVE
52353	9	CYSTOURETERO W/LITHOTRIPSY
52354	6	CYSTOURETRO & OR PYELOSCOPE
52355	6	CYSTOURETERO W/EXCISE TUMOR
CPT SUBSECTION: TRANSURETHRAL SURGERY (VESICAL NECK AND PROSTATE)		
52400	5	CYSTOURETERO W/CONGEN REPR
52402 ³	5	CYSTOURETHRO CUT EJACUL DUCT
52450	5	INCISION OF PROSTATE
52500	5	REVISION OF BLADDER NECK
52601	6	PROSTATECTOMY (TURP)
52606	2	CONTROL POSTOP BLEEDING
52612	4	PROSTATECTOMY, FIRST STAGE
52614	2	PROSTATECTOMY, SECOND STAGE
52620	2	REMOVE RESIDUAL PROSTATE
52630	4	REMOVE PROSTATE REGROWTH
52640	4	RELIEVE BLADDER CONTRACTURE
52647	10	LASER SURGERY OF PROSTATE
52648	10	LASER SURGERY OF PROSTATE
52700	4	DRAINAGE OF PROSTATE ABSCESS
URETHRA		
CPT SUBSECTION: INCISION		
53000	2	INCISION OF URETHRA
53010	2	INCISION OF URETHRA
53020	2	INCISION OF URETHRA
53040	4	DRAINAGE OF URETHRA ABSCESS
53080	5	DRAINAGE OF URINARY LEAKAGE
CPT SUBSECTION: EXCISION		
53200	2	BIOPSY OF URETHRA
53210	7	REMOVAL OF URETHRA
53215	7	REMOVAL OF URETHRA
53220	4	TREATMENT OF URETHRA LESION
53230	4	REMOVAL OF URETHRA LESION
53235	5	REMOVAL OF URETHRA LESION
53240	4	SURGERY FOR URETHRA POUCH
53250	4	REMOVAL OF URETHRA GLAND
53260	4	TREATMENT OF URETHRA LESION
53265	4	TREATMENT OF URETHRA LESION
53270	4	REMOVAL OF URETHRA GLAND
53275	4	REMOVAL OF URETHRA GLAND
CPT SUBSECTION: REPAIR		
53400	5	REVISE URETHRA, STAGE 1
53405	4	REVISE URETHRA, STAGE 2

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URINARY SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
53410	4	RECONSTRUCTION OF URETHRA
53420	5	RECONSTRUCT URETHRA, STAGE 1
53425	4	RECONSTRUCT URETHRA, STAGE 2
53430	4	RECONSTRUCTION OF URETHRA
53431	4	RECONSTRUCT URETHRA/BLADDER
53440	4	CORRECT BLADDER FUNCTION
53442	2	REMOVE PERINEAL PROSTHESIS
53444	4	INSERT TANDEM CUFF
53445	2	INSERT URO/VES NCK SPHINCTER
53446	2	REMOVE URO SPHINCTER
53447	2	REMOVE/REPLACE UR SPHINCTER
53449	2	REPAIR URO SPHINCTER
53450	2	REVISION OF URETHRA
53460	2	REVISION OF URETHRA
CPT SUBSECTION: SUTURE		
53502	4	REPAIR OF URETHRA INJURY
53505	4	REPAIR OF URETHRA INJURY
53510	4	REPAIR OF URETHRA INJURY
53515	4	REPAIR OF URETHRA INJURY
53520	4	REPAIR OF URETHRA DEFECT
CPT SUBSECTION: MANIPULATION		
53605	4	DILATE URETHRA STRICTURE
53665	2	DILATION OF URETHRA
CPT SUBSECTION: OTHER PROCEDURES		
53850 ⁴	10	PROSTATIC MICROWAVE THERMOTX

MALE GENITAL SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
PENIS		
CPT SUBSECTION: INCISION		
54000	4	SLITTING OF PREPUCE
54001	4	SLITTING OF PREPUCE
54015	6	DRAIN PENIS LESION
CPT SUBSECTION: DESTRUCTION		
54057	2	LASER SURG, PENIS LESION(S)
54060	2	EXCISION OF PENIS LESION(S)
54065	2	DESTRUCTION, PENIS LESION(S)
CPT SUBSECTION: EXCISION		
54100	2	BIOPSY OF PENIS
54105	2	BIOPSY OF PENIS
54110	4	TREATMENT OF PENIS LESION
54111	4	TREAT PENIS LESION, GRAFT
54112	4	TREAT PENIS LESION, GRAFT
54115	2	TREATMENT OF PENIS LESION

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MALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
54120	4	PARTIAL REMOVAL OF PENIS
54150	2	CIRCUMCISION
54152 ⁸	2	CIRCUMCISION
54160	4	CIRCUMCISION
54161	6	CIRCUMCISION
54162	4	LYSIS PENIL CIRCUMCIS LESION
54163	4	REPAIR OF CIRCUMCISION
54164	4	FRENULOTOMY OF PENIS
CPT SUBSECTION: INTRODUCTION		
54205	6	TREATMENT OF PENIS LESION
54220	2	TREATMENT OF PENIS LESION
CPT SUBSECTION: REPAIR		
54300	5	REVISION OF PENIS
54304	5	REVISION OF PENIS
54308	5	RECONSTRUCTION OF URETHRA
54312	5	RECONSTRUCTION OF URETHRA
54316	5	RECONSTRUCTION OF URETHRA
54318	5	RECONSTRUCTION OF URETHRA
54322	5	RECONSTRUCTION OF URETHRA
54324	5	RECONSTRUCTION OF URETHRA
54326	5	RECONSTRUCTION OF URETHRA
54328	5	REVISE PENIS/URETHRA
54340	5	SECONDARY URETHRAL SURGERY
54344	5	SECONDARY URETHRAL SURGERY
54348	5	SECONDARY URETHRAL SURGERY
54352	5	RECONSTRUCT URETHRA/PENIS
54360	5	PENIS PLASTIC SURGERY
54380	5	REPAIR PENIS
54385	5	REPAIR PENIS
54400	5	INSERT SEMI-RIGID PROSTHESIS
54401	5	INSERT SEMI-RIGID PROSTHESIS
54405	5	INSERT MULTI-COMP PENIS PROS
54406	5	REMOVE MULTI-COMP PENIS PROSTH
54408	5	REPAIR MULTI-COMP PENIS PROS
54410	5	REMOVE/REPLACE PENIS PROSTH
54415	5	REMOVE SELF-CONTD PENIS PROS
54416	5	REMOV/REPL PENIS CONTAIN PROS
54420	6	REVISION OF PENIS
54435	6	REVISION OF PENIS
54440	6	REPAIR OF PENIS
CPT SUBSECTION: MANIPULATION		
54450	2	PREPUTIAL STRETCHING
TESTIS		
CPT SUBSECTION: EXCISION		
54500	2	BIOPSY OF TESTIS
54505	2	BIOPSY OF TESTIS

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MALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
54512	4	EXCISE LESION TESTIS
54520	5	REMOVAL OF TESTIS
54522	5	ORCHIECTOMY, PARTIAL
54530	6	REMOVAL OF TESTIS
54550	6	EXPLORATION FOR TESTIS
CPT SUBSECTION: REPAIR		
54600	6	REDUCE TESTIS TORSION
54620	5	SUSPENSION OF TESTIS
54640	8	SUSPENSION OF TESTIS
54660	4	REVISION OF TESTIS
54670	5	REPAIR TESTIS INJURY
54680	5	RELOCATION OF TESTIS(ES)
CPT SUBSECTION: LAPAROSCOPY		
54690	10	LAPAROSCOPY, ORCHIECTOMY
EPIDIDYMIS		
CPT SUBSECTION: INCISION		
54700	4	DRAINAGE OF SCROTUM
CPT SUBSECTION: EXCISION		
54800	2	BIOPSY OF EPIDIDYMIS
54820 ⁸	2	EXPLORATION OF EPIDIDYMIS
54830	5	REMOVE EPIDIDYMIS LESION
54840	6	REMOVE EPIDIDYMIS LESION
54860	5	REMOVAL OF EPIDIDYMIS
54861	6	REMOVAL OF EPIDIDYMIS
54865 ⁷	2	EXPLORE EPIDIDYMIS
CPT SUBSECTION: REPAIR		
54900	6	FUSION OF SPERMATIC DUCTS
54901	6	FUSION OF SPERMATIC DUCTS
TUNICA VAGINALIS		
CPT SUBSECTION: EXCISION		
55040	7	REMOVAL OF HYDROCELE
55041	7	REMOVAL OF HYDROCELES
CPT SUBSECTION: REPAIR		
55060	6	REPAIR OF HYDROCELE
SCROTUM		
CPT SUBSECTION: INCISION		
55100	2	DRAINAGE OF SCROTUM ABSCESS
55110	4	EXPLORE SCROTUM
55120	4	REMOVAL OF SCROTUM LESION
CPT SUBSECTION: EXCISION		
55150	2	REMOVAL OF SCROTUM
CPT SUBSECTION: REPAIR		
55175	2	REVISION OF SCROTUM
55180	4	REVISION OF SCROTUM

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MALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
VAS DEFERENS		
CPT SUBSECTION: INCISION		
55200	4	INCISION OF SPERM DUCT
CPT SUBSECTION: EXCISION		
55250	4	REMOVAL OF SPERM DUCT(S)
CPT SUBSECTION: REPAIR		
55400	2	REPAIR OF SPERM DUCT
SPERMATIC CORD		
CPT SUBSECTION: EXCISION		
55500	5	REMOVAL OF HYDROCELE
55520	6	REMOVAL OF SPERM CORD LESION
55530	8	REVISE SPERMATIC CORD VEINS
55535	6	REVISE SPERMATIC CORD VEINS
55540	7	REVISE HERNIA & SPERM VEINS
CPT SUBSECTION: LAPAROSCOPY		
55550	10	LAPARO LIGATE SPERMATIC VEIN
SEMINAL VESICLES		
CPT SUBSECTION: EXCISION		
55680	2	REMOVE SPERM POUCH LESION
PROSTATE		
CPT SUBSECTION: INCISION		
55700	3	BIOPSY OF PROSTATE
55705	4	BIOPSY OF PROSTATE
55720	2	DRAINAGE OF PROSTATE ABSCESS
55725	4	DRAINAGE OF PROSTATE ABSCESS
CPT SUBSECTION: EXCISION		
55859 ⁸	10	PERCUT/NEEDLE INSERT, PROS
CPT SUBSECTION: OTHER PROCEDURES		
55873 ³	10	CRYOABLATE PROSTATE
55875 ⁷	10	TRANSPERI NEEDLE PLACE, PROS

FEMALE GENITAL SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
VULVA, PERINEUM, AND INTROITUS		
CPT SUBSECTION: INCISION		
56440	4	SURGERY FOR VULVA LESION
56441	2	LYSIS OF LABIAL LESION(S)
56442 ⁷	2	HYMENOTOMY
CPT SUBSECTION: DESTRUCTION		
56515	5	DESTROY VULVA LESION/S COMPL
CPT SUBSECTION: EXCISION		
56620	7	PARTIAL REMOVAL OF VULVA

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FEMALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
56625	9	COMPLETE REMOVAL OF VULVA
56700	2	PARTIAL REMOVAL OF HYMEN
56720 ⁸	2	INCISION OF HYMEN
56740	5	REMOVE VAGINA GLAND LESION
CPT SUBSECTION: REPAIR		
56800	5	REPAIR OF VAGINA
56810	7	REPAIR OF PERINEUM
VAGINA		
CPT SUBSECTION: INCISION		
57000	2	EXPLORATION OF VAGINA
57010	4	DRAINAGE OF PELVIC ABSCESS
57020	4	DRAINAGE OF PELVIC FLUID
57023	2	I & D VAG HEMATOMA, NON-OB
CPT SUBSECTION: DESTRUCTION		
57065	2	DESTROY VAG LESIONS, COMPLEX
CPT SUBSECTION: EXCISION		
57105	4	BIOPSY OF VAGINA
57130	4	REMOVE VAGINA LESION
57135	4	REMOVE VAGINA LESION
CPT SUBSECTION: INTRODUCTION		
57155 ³	4	INSERT UTERI TANDEM/OVOIDS
57180	2	TREAT VAGINAL BLEEDING
CPT SUBSECTION: REPAIR		
57200	2	REPAIR OF VAGINA
57210	4	REPAIR VAGINA/PERINEUM
57220	5	REVISION OF URETHRA
57230	5	REPAIR OF URETHRAL LESION
57240	7	REPAIR BLADDER & VAGINA
57250	7	REPAIR RECTUM & VAGINA
57260	7	REPAIR OF VAGINA
57265	9	EXTENSIVE REPAIR OF VAGINA
57267 ⁷	9	INSERT MESH/PELVIC FLR ADDON
57268	5	REPAIR OF BOWEL BULGE
57288 ³	7	REPAIR BLADDER DEFECT
57289	7	REPAIR BLADDER AND VAGINA
57291	7	CONSTRUCTION OF VAGINA
57300	5	REPAIR RECTUM-VAGINA FISTULA
CPT SUBSECTION: MANIPULATION		
57400	4	DILATION OF VAGINA
57410	4	PELVIC EXAMINATION
57415	4	REMOVE VAGINAL FOREIGN BODY
CERVIX UTERI		
CPT SUBSECTION: EXCISION		
57513	4	LASER SURGERY OF CERVIX
57520	7	CONIZATION OF CERVIX

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CHAPTER 9, ADDENDUM B

TRICARE-APPROVED AMBULATORY SURGERY PROCEDURES ON OR AFTER 11/01/2003

FEMALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
57522	6	CONIZATION OF CERVIX
57530	5	REMOVAL OF CERVIX
57550	5	REMOVAL OF RESIDUAL CERVIX
57556	7	REMOVE CERVIX, REPAIR BOWEL
57558 ⁷	5	D&C OF CERVICAL STUMP
CPT SUBSECTION: REPAIR		
57700	2	REVISION OF CERVIX
57720	5	REVISION OF CERVIX
CPT SUBSECTION: MANIPULATION		
57820 ⁸	5	D & C OF RESIDUAL CERVIX
CORPUS UTERI		
CPT SUBSECTION: EXCISION		
58120	6	DILATION AND CURETTAGE
58145	7	REMOVAL OF UTERUS LESION
CPT SUBSECTION: INTRODUCTION		
58346 ³	4	INSERT HEYMAN UTERI CAPSULE
58350	5	REOPEN FALLOPIAN TUBE
58353	9	ENDOMETR ABLATE, THERMAL
CPT SUBSECTION: LAPAROSCOPY		
58545	10	LAPAROSCOPIC MYOMECTOMY
58546	10	LAPARO-MYOMECTOMY, COMPLEX
58550	10	LAPARO-ASST VAG HYSTERECTOMY
58555	2	HYSTEROSCOPY, DX, SEP PROC
58558	7	HYSTEROSCOPY, BIOPSY
58559	4	HYSTEROSCOPY, LYSIS
58560	5	HYSTEROSCOPY, RESECT SEPTUM
58561	5	HYSTEROSCOPY, REMOVE MYOMA
58562	5	HYSTEROSCOPY, REMOVE FB
58563	10	HYSTEROSCOPY, ABLATION
58565 ³	10	HYSTEROSCOPY, STERILIZATION
OVIDUCT		
CPT SUBSECTION: INCISION		
58600	9	DIVISION OF FALLOPIAN TUBE
58615	9	OCCLUDE FALLOPIAN TUBE(S)
CPT SUBSECTION: LAPAROSCOPY		
58660	9	LAPAROSCOPY, LYSIS
58661	10	LAPAROSCOPY, REMOVE ADNEXA
58662	9	LAPAROSCOPY, EXCISE LESIONS
58670	9	LAPAROSCOPY, TUBAL CAUTERY
58671	8	LAPAROSCOPY, TUBAL BLOCK
58672	7	LAPAROSCOPY, FIMBRIOPLASTY
58673	7	LAPAROSCOPY, SALPINGOSTOMY
OVARY		
CPT SUBSECTION: INCISION		
58800	5	DRAINAGE OF OVARIAN CYST(S)

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TRICARE-APPROVED AMBULATORY SURGERY PROCEDURES ON OR AFTER 11/01/2003

FEMALE GENITAL SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
58820	5	DRAIN OVARY ABSCESS, OPEN
CPT SUBSECTION: EXCISION		
58900	5	BIOPSY OF OVARY(S)
DELIVERY, ANTEPARTUM, AND POSTPARTUM CARE		
CPT SUBSECTION: EXCISION		
59160	5	D & C AFTER DELIVERY
CPT SUBSECTION: REPAIR		
59320	2	REVISION OF CERVIX
CPT SUBSECTION: VAGINAL DELIVERY, ANTEPARTUM AND POSTPARTUM CARE		
59414	1	DELIVER PLACENTA
CPT SUBSECTION: ABORTION		
59812	6	TREATMENT OF MISCARRIAGE
59820	6	CARE OF MISCARRIAGE
59821	7	TREATMENT OF MISCARRIAGE
59840	7	ABORTION
59841	7	ABORTION
CPT SUBSECTION: OTHER PROCEDURES		
59870	7	EVACUATE M OLE OF UTERUS
59871	7	REMOVE CERCLAGE SUTURE

ENDOCRINE SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
THYROID GLAND		
CPT SUBSECTION: INCISION		
60000	2	DRAIN THYROID/TONGUE CYST
CPT SUBSECTION: EXCISION		
60200	4	REMOVE THYROID LESION
60280	6	REMOVE THYROID DUCT LESION
60281	6	REMOVE THYROID DUCT LESION

NERVOUS SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
SKULL, MENINGES, AND BRAIN		
CPT SUBSECTION: PUNCTURE FOR INJECTION, DRAINAGE, OR ASPIRATION		
61020	2	REMOVE BRAIN CAVITY FLUID
61026	2	INJECTION INTO BRAIN CANAL
61050	2	REMOVE BRAIN CANAL FLUID
61055	2	INJECTION INTO BRAIN CANAL
61070	2	BRAIN CANAL SHUNT PROCEDURE
CPT SUBSECTION: TWIST DRILL, BURR HOLE(S) OR TREPHINE		
61215	5	INSERT BRAIN-FLUID DEVICE

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NERVOUS SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: STEREOTAXIS		
61790	5	TREAT TRIGEMINAL NERVE
61791	5	TREAT TRIGEMINAL TRACT
61795 ⁷	2	BRAIN SURGERY USING COMPUTER
CPT SUBSECTION: NEUROSTIMULATORS, INTRACRANIAL		
61885	4	IMPLANT NEUROSTIM ONE ARRAY
61886	5	IMPLANT NEUROSTIM ARRAYS
61888	2	REVISE/REMOVE NEURORECEIVER
CPT SUBSECTION: CSF SHUNT		
62194	2	REPLACE/IRRIGATE CATHETER
62225	2	REPLACE/IRRIGATE CATHETER
62230	4	REPLACE/REVISE BRAIN SHUNT
62263	2	LYSIS EPIDURAL ADHESIONS
62264 ³	2	EPIDURAL LYSIS ON SINGLE DAY
SPINE AND SPINAL CORD		
CPT SUBSECTION: PUNCTURE FOR INJECTION, DRAINAGE, OR ASPIRATION		
62268	2	DRAIN SPINAL CORD CYST
62269	2	NEEDLE BIOPSY, SPINAL CORD
62270	1	SPINAL FLUID TAP, DIAGNOSTIC
62272	2	DRAIN CEREBRO SPINAL FLUID
62273	1	TREAT EPIDURAL SPINE LESION
62280	2	TREAT SPINAL CORD LESION
62281	2	TREAT SPINAL CORD LESION
62282	2	TREAT SPINAL CANAL LESION
62287	10	PERCUTANEOUS DISKECTOMY
62294	5	INJECTION INTO SPINAL ARTERY
62310	2	INJECT SPINE C/T
62311	2	INJECT SPINE L/S (CD)
62318	2	INJECT SPINE W/CATH, C/T
62319	2	INJECT SPINE W/CATH L/S (CD)
CPT SUBSECTION: CATHETER IMPLANTATION		
62350	4	IMPLANT SPINAL CANAL CATH
62355	4	REMOVE SPINAL CANAL CATHETER
CPT SUBSECTION: RESERVOIR/PUMP IMPLANTATION		
62360	4	INSERT SPINE INFUSION DEVICE
62361	4	IMPLANT SPINE INFUSION PUMP
62362	4	IMPLANT SPINE INFUSION PUMP
62365	4	REMOVE SPINE INFUSION DEVICE
CPT SUBSECTION: STEREOTAXIS		
63600	4	REMOVE SPINAL CORD LESION
63610	2	STIMULATION OF SPINAL CORD
CPT SUBSECTION: NEUROSTIMULATORS, SPINAL		
63650	4	IMPLANT NEUROELECTRODES
63660	2	REVISE/REMOVE NEUROELECTRODE
63685	4	IMPLANT NEURORECEIVER

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NERVOUS SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
63688	2	REVISE/REMOVE NEURORECEIVER
CPT SUBSECTION: SHUNT, SPINAL CSF		
63744	5	REVISION OF SPINAL SHUNT
63746	4	REMOVAL OF SPINAL SHUNT

**EXTRACRANIAL NERVES, PERIPHERAL NERVES,
AND AUTONOMIC NERVOUS SYSTEM**

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC		

CPT SUBSECTION: SOMATIC NERVES

64410	2	INJECTION FOR NERVE BLOCK
64415	2	INJECTION FOR NERVE BLOCK
64417	2	INJECTION FOR NERVE BLOCK
64420	2	INJECTION FOR NERVE BLOCK
64421	2	INJECTION FOR NERVE BLOCK
64430	2	INJECTION FOR NERVE BLOCK
64470	2	INJ PARAVERTEBRAL C/T
64472	2	INJ PARAVERTEBRAL C/T ADD-ON
64475	2	INJ PARAVERTEBRAL L/S
64476	2	INJ PARAVERTEBRAL L/S ADD-ON
64479	2	INJ FORAMEN EPIDURAL C/T
64480	2	INJ FORAMEN EPIDURAL ADD-ON
64483	2	INJ FORAMEN EPIDURAL L/S
64484	2	INJ FORAMEN EPIDURAL ADD-ON

CPT SUBSECTION: SYMPATHETIC NERVES

64510	2	INJECTION FOR NERVE BLOCK
64517 ³	4	N BLOCK INJ, HYPOGAS PLXS
64520	2	INJECTION FOR NERVE BLOCK
64530	2	INJECTION FOR NERVE BLOCK

CPT SUBSECTION: NEUROSTIMULATORS, PERIPHERAL NERVE

64553	2	IMPLANT NEUROELECTRODES
64561 ³	5	IMPLANT NEUROELECTRODES
64573	2	IMPLANT NEUROELECTRODES
64575	2	IMPLANT NEUROELECTRODES
64577	2	IMPLANT NEUROELECTRODES
64580	2	IMPLANT NEUROELECTRODES
64585	2	REVISE/REMOVE NEUROELECTRODE
64590	4	IMPLANT NEURORECEIVER

DESTRUCTION BY NEUROLYTIC AGENT (E.G., CHEMICAL, THERMAL, ELECTRICAL, RADIOFREQUENCY)

CPT SUBSECTION: SOMATIC NERVES

64600	2	INJECTION TREATMENT OF NERVE
64605	2	INJECTION TREATMENT OF NERVE
64610	2	INJECTION TREATMENT OF NERVE
64620	2	INJECTION TREATMENT OF NERVE

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EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
64622	5	DESTR PARAVERTEBRL NERVE L/S
64623	2	DESTR PARAVERTEBRAL N ADD-ON
64626	2	DESTR PARAVERTEBRL NERVE C/T
64627	2	DESTR PARAVERTEBRAL N ADD-ON
64630	4	INJECTION TREATMENT OF NERVE
CPT SUBSECTION: SYMPATHETIC NERVES		
64680	4	INJECTION TREATMENT OF NERVE
64681 ³	3	INJECTION TREATMENT OF NERVE
CPT SUBSECTION: NEUROLOPLASTY (EXPLANATION, NEUROLYSIS OR NERVE DEOMPRESSION)		
64702	2	REVISE FINGER/TOE NERVE
64704	2	REVISE HAND/FOOT NERVE
64708	4	REVISE ARM/LEG NERVE
64712	4	REVISION OF SCIATIC NERVE
64713	4	REVISION OF ARM NERVE(S)
64714	4	REVISE LOW BACK NERVE(S)
64716	5	REVISION OF CRANIAL NERVE
64718	9	REVISE ULNAR NERVE AT ELBOW
64719	4	REVISE ULNAR NERVE AT WRIST
64721	7	CARPAL TUNNEL SURGERY
64722	2	RELIEVE PRESSURE ON NERVE(S)
64726	2	RELEASE FOOT/TOE NERVE
64727	2	INTERNAL NERVE REVISION
CPT SUBSECTION: TRANSECTION OR AVULSION OF NERVE		
64732	4	INCISION OF BROW NERVE
64734	4	INCISION OF CHEEK NERVE
64736	4	INCISION OF CHIN NERVE
64738	4	INCISION OF JAW NERVE
64740	4	INCISION OF TONGUE NERVE
64742	4	INCISION OF FACIAL NERVE
64744	4	INCISE NERVE, BACK OF HEAD
64746	4	INCISE DIAPHRAGM NERVE
64771	4	SEVER CRANIAL NERVE
64772	4	INCISION OF SPINAL NERVE
CPT SUBSECTION: EXCISION-SOMATIC NERVES		
64774	4	REMOVE SKIN NERVE LESION
64776	5	REMOVE DIGIT NERVE LESION
64778	4	DIGIT NERVE SURGERY ADD-ON
64782	5	REMOVE LIMB NERVE LESION
64783	4	LIMB NERVE SURGERY ADD-ON
64784	5	REMOVE NERVE LESION
64786	5	REMOVE SCIATIC NERVE LESION
64787	4	IMPLANT NERVE END
64788	5	REMOVE SKIN NERVE LESION
64790	5	REMOVAL OF NERVE LESION

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EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
64792	5	REMOVAL OF NERVE LESION
64795	4	BIOPSY OF NERVE
CPT SUBSECTION: EXCISION-SYMPATHETIC NERVES		
64802	4	REMOVE SYMPATHETIC NERVES
64821	6	REMOVE SYMPATHETIC NERVES
CPT SUBSECTION: NERVE REPAIR BY SUTURE (NEURORRHAPHY)		
64831	6	REPAIR OF DIGIT NERVE
64832	2	REPAIR NERVE ADD-ON
64834	4	REPAIR OF HAND OR FOOT NERVE
64835	5	REPAIR OF HAND OR FOOT NERVE
64836	5	REPAIR OF HAND OR FOOT NERVE
64837	2	REPAIR NERVE ADD-ON
64840	4	REPAIR OF LEG NERVE
64856	4	REPAIR/TRANSPOSE NERVE
64857	4	REPAIR ARM/LEG NERVE
64858	4	REPAIR SCIATIC NERVE
64859	2	NERVE SURGERY
64861	5	REPAIR OF ARM NERVES
64862	5	REPAIR OF LOW BACK NERVES
64864	5	REPAIR OF FACIAL NERVE
64865	6	REPAIR OF FACIAL NERVE
64870	6	FUSION OF FACIAL/OTHER NERVE
64872	4	SUBSEQUENT REPAIR OF NERVE
64874	5	REPAIR & REVISE NERVE ADD-ON
64876	5	REPAIR NERVE/SHORTEN BONE
CPT SUBSECTION: NEURORRHAPHY WITH NERVE GRAFT		
64885	4	NERVE GRAFT, HEAD OR NECK
64886	4	NERVE GRAFT, HEAD OR NECK
64890	4	NERVE GRAFT, HAND OR FOOT
64891	4	NERVE GRAFT, HAND OR FOOT
64892	4	NERVE GRAFT, ARM OR LEG
64893	4	NERVE GRAFT, ARM OR LEG
64895	5	NERVE GRAFT, HAND OR FOOT
64896	5	NERVE GRAFT, HAND OR FOOT
64897	5	NERVE GRAFT, ARM OR LEG
64898	5	NERVE GRAFT, ARM OR LEG
64901	4	NERVE GRAFT ADD-ON
64902	4	NERVE GRAFT ADD-ON
64905	4	NERVE PEDICLE TRANSFER
64907	2	NERVE PEDICLE TRANSFER

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EYE AND OCULAR ADNEXA

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
EYEBALL		
CPT SUBSECTION: REMOVAL OF EYE		
65091	5	REVISE EYE
65093	5	REVISE EYE WITH IMPLANT
65101	5	REMOVAL OF EYE
65103	5	REMOVE EYE/INSERT IMPLANT
65105	6	REMOVE EYE/ATTACH IMPLANT
65110	7	REMOVAL OF EYE
65112	9	REMOVE EYE/REVISE SOCKET
65114	9	REMOVE EYE/REVISE SOCKET
CPT SUBSECTION: SECONDARY IMPLANT PROCEDURES		
65130	5	INSERT OCULAR IMPLANT
65135	4	INSERT OCULAR IMPLANT
65140	5	ATTACH OCULAR IMPLANT
65150	4	REVISE OCULAR IMPLANT
65155	5	REINSERT OCULAR IMPLANT
65175	2	REMOVAL OF OCULAR IMPLANT
CPT SUBSECTION: REMOVAL OF OCULAR FOREIGN BODY		
65235	4	REMOVE FOREIGN BODY FROM EYE
65260	5	REMOVE FOREIGN BODY FROM EYE
65265	6	REMOVE FOREIGN BODY FROM EYE
65270	4	REPAIR OF EYE WOUND
65272	4	REPAIR OF EYE WOUND
65275	6	REPAIR OF EYE WOUND
65280	6	REPAIR OF EYE WOUND
65285	6	REPAIR OF EYE WOUND
65290	5	REPAIR OF EYE SOCKET WOUND
ANTERIOR SEGMENT - CORNEA		
CPT SUBSECTION: EXCISION		
65400	2	REMOVAL OF EYE LESION
65410	4	BIOPSY OF CORNEA
65420	4	REMOVAL OF EYE LESION
65426	6	REMOVAL OF EYE LESION
CPT SUBSECTION: KERATOPLASTY		
65710	9	CORNEAL TRANSPLANT
65730	9	CORNEAL TRANSPLANT
65750	9	CORNEAL TRANSPLANT
65755	9	CORNEAL TRANSPLANT
CPT SUBSECTION: OTHER PROCEDURES		
65770	9	REVISE CORNEA WITH IMPLANT
65772	6	CORRECTION OF ASTIGMATISM
65775	6	CORRECTION OF ASTIGMATISM
65780 ³	7	OCULAR RECONST, TRANSPLANT
65781 ³	7	OCULAR RECONST, TRANSPLANT
65782 ³	7	OCULAR RECONST, TRANSPLANT

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
ANTERIOR SEGMENT - ANTERIOR CHAMBER		
CPT SUBSECTION: INCISION		
65800	2	DRAINAGE OF EYE
65805	2	DRAINAGE OF EYE
65810	5	DRAINAGE OF EYE
65815	4	DRAINAGE OF EYE
65820 ³	2	RELIEVE INNER EYE PRESSURE
65850	6	INCISION OF EYE
CPT SUBSECTION: OTHER PROCEDURES		
65865	2	INCISE INNER EYE ADHESIONS
65870	6	INCISE INNER EYE ADHESIONS
65875	6	INCISE INNER EYE ADHESIONS
65880	6	INCISE INNER EYE ADHESIONS
65900	7	REMOVE EYE LESION
65920	9	REMOVE IMPLANT OF EYE
65930	7	REMOVE BLOOD CLOT FROM EYE
66020	2	INJECTION TREATMENT OF EYE
66030	2	INJECTION TREATMENT OF EYE
ANTERIOR SEGMENT - ANTERIOR SCLERA		
CPT SUBSECTION: EXCISION		
66130	9	REMOVE EYE LESION
66150	6	GLAUCOMA SURGERY
66155	6	GLAUCOMA SURGERY
66160	4	GLAUCOMA SURGERY
66165	6	GLAUCOMA SURGERY
66170	6	GLAUCOMA SURGERY
66172	6	INCISION OF EYE
66180	7	IMPLANT EYE SHUNT
66185	4	REVISE EYE SHUNT
CPT SUBSECTION: REPAIR		
66220	5	REPAIR EYE LESION
66225	6	REPAIR/GRAFT EYE LESION
CPT SUBSECTION: REVISION OPERATIVE WOUND		
66250	4	FOLLOW-UP SURGERY OF EYE
ANTERIOR SEGMENT - IRIS, CILIARY BODY		
CPT SUBSECTION: IRIDOTOMY, IRIDECTOMY		
66500	2	INCISION OF IRIS
66505	2	INCISION OF IRIS
66600	5	REMOVE IRIS AND LESION
66605	5	REMOVAL OF IRIS
66625	5	REMOVAL OF IRIS
66630	5	REMOVAL OF IRIS
66635	5	REMOVAL OF IRIS
CPT SUBSECTION: REPAIR		
66680	5	REPAIR IRIS & CILIARY BODY

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
66682	4	REPAIR IRIS & CILIARY BODY
CPT SUBSECTION: DESTRUCTION		
66700	4	DESTRUCTION, CILIARY BODY
66710	4	DESTRUCTION, CILIARY BODY
66711 ³	4	CILIARY ENDOSCOPIC ABLATION
66720	4	DESTRUCTION, CILIARY BODY
66740	4	DESTRUCTION, CILIARY BODY
ANTERIOR SEGMENT - LENS		
CPT SUBSECTION: INCISION		
66821	2	AFTER CATARACT LASER SURGERY
66825	6	REPOSITION INTRAOCULAR LENS
CPT SUBSECTION: REMOVAL CATARACT		
66830	6	REMOVAL OF LENS LESION
66840	6	REMOVAL OF LENS MATERIAL
66850	9	REMOVAL OF LENS MATERIAL
66852	6	REMOVAL OF LENS MATERIAL
66920	6	EXTRACTION OF LENS
66930	7	EXTRACTION OF LENS
66940	7	EXTRACTION OF LENS
66982	9	CATARACT SURGERY, COMPLEX
66983	9	CATARACT SURG W/IOL, 1 STAGE
66984	9	CATARACT SURG W/IOL, I STAGE
66985	8	INSERT LENS PROSTHESIS
66986	8	EXCHANGE LENS PROSTHESIS
CPT SUBSECTION: POSTERIOR SEGMENT - VITREOUS		
67005	6	PARTIAL REMOVAL OF EYE FLUID
67010	6	PARTIAL REMOVAL OF EYE FLUID
67015	2	RELEASE OF EYE FLUID
67025	2	REPLACE EYE FLUID
67027	6	IMPLANT EYE DRUG SYSTEM
67030	2	INCISE INNER EYE STRANDS
67031	4	LASER SURGERY, EYE STRANDS
67036	6	REMOVAL OF INNER EYE FLUID
67038	10	STRIP RETINAL MEMBRANE
67039	9	LASER TREATMENT OF RETINA
67040	10	LASER TREATMENT OF RETINA
POSTERIOR SEGMENT - RETINAL DETACHMENT		
CPT SUBSECTION: REPAIR		
67107	10	REPAIR DETACHED RETINA
67108	10	REPAIR DETACHED RETINA
67112	9	REREPAIR DETACHED RETINA
67115	4	RELEASE ENCIRCLING MATERIAL
67120	4	REMOVE EYE IMPLANT MATERIAL
67121	4	REMOVE EYE IMPLANT MATERIAL
CPT SUBSECTION: PROPHYLAXIS		
67141	4	TREATMENT OF RETINA

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
POSTERIOR SEGMENT - OTHER PROCEDURES		
CPT SUBSECTION: DESTRUCTION - RETINA, CHOROID		
67218	7	TREATMENT OF RETINAL LESION
67227	2	TREATMENT OF RETINAL LESION
CPT SUBSECTION: SCLERAL REPAIR		
67250	5	REINFORCE EYE WALL
67255	5	REINFORCE/GRAFT EYE WALL
CPT SUBSECTION: OCULARY ADNEXA - EXTRAOCULAR MUSCLES		
67311	8	REVISE EYE MUSCLE
67312	9	REVISE TWO EYE MUSCLES
67314	8	REVISE EYE MUSCLE
67316	6	REVISE TWO EYE MUSCLES
67318	6	REVISE EYE MUSCLE(S)
67320	6	REVISE EYE MUSCLE(S) ADD-ON
67331	6	EYE SURGERY FOLLOW-UP ADD-ON
67332	6	REREVISE EYE MUSCLES ADD-ON
67334	6	REVISE EYE MUSCLE W/SUTURE
67335	6	EYE SUTURE DURING SURGERY
67340	6	REVISE EYE MUSCLE ADD-ON
67343 ³	9	RELEASE EYE TISSUE
67346 ⁷	2	BIOPSY, EYE MUSCLE
CPT SUBSECTION: OTHER PROCEDURES		
67350 ⁸	2	BIOPSY EYE MUSCLE
OCULAR ADNEXA - ORBIT		
CPT SUBSECTION: EXPLORATION, EXCISION, DECOMPRESSION		
67400	5	EXPLORE/BIOPSY EYE SOCKET
67405	6	EXPLORE/DRAIN EYE SOCKET
67412	7	EXPLORE/TREAT EYE SOCKET
67413	7	EXPLORE/TREAT EYE SOCKET
67415	2	ASPIRATION, ORBITAL CONTENTS
67420	7	EXPLORE/TREAT EYE SOCKET
67430	7	EXPLORE/TREAT EYE SOCKET
67440	7	EXPLORE/DRAIN EYE SOCKET
67445 ³	7	EXPLR/DECOMPRESS EYE SOCKET
67450	7	EXPLORE/BIOPSY EYE SOCKET
CPT SUBSECTION: OTHER PROCEDURES		
67550	6	INSERT EYE SOCKET IMPLANT
67570 ³	6	DECOMPRESS OPTIC NERVE
67560	4	REVISE EYE SOCKET IMPLANT
OCULAR ADNEXA - EYELIDS		
CPT SUBSECTION: INCISION		
67715	2	INCISION OF EYELID FOLD
CPT SUBSECTION: EXCISION OR REMOVAL OF LESION INVOLVING MORE THAN SKIN (I.E., INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA)		
67808	4	REMOVE EYELID LESION(S)

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
67830	4	REVISE EYELASHES
67835	4	REVISE EYELASHES
CPT SUBSECTION: TARSORRHAPHY		
67880	5	REVISION OF EYELID
67882	5	REVISION OF EYELID
CPT SUBSECTION: REPAIR OF BROW/PTOSIS BLEPHAROPTOSIS, LID RETRACTION		
67900	6	REPAIR BROW DEFECT
67901	7	REPAIR BROW DEFECT
67902	7	REPAIR EYELID DEFECT
67903	6	REPAIR EYELID DEFECT
67904	6	REPAIR EYELID DEFECT
67906	7	REPAIR EYELID DEFECT
67908	6	REPAIR EYELID DEFECT
67909	6	REVISE EYELID DEFECT
67911	5	REVISE EYELID DEFECT
67912 ³	5	CORRECTION EYELID W/IMPLANT
CPT SUBSECTION: REPAIR ECTROPION, ENTROPION		
67914	5	REPAIR EYELID DEFECT
67916	6	REPAIR EYELID DEFECT
67917	6	REPAIR EYELID DEFECT
67921	5	REPAIR EYELID DEFECT
67923	6	REPAIR EYELID DEFECT
67924	6	REPAIR EYELID DEFECT
CPT SUBSECTION: RECONSTRUCTIVE SURGERY, BLEPHAROPLASTY INVOLVING MORE THAN SKIN (I.E., INVOLVING LID MARGIN, TARSUS, AND/OR PALPERBRAL CONJUNCTIVA)		
67935	4	REPAIR EYELID WOUND
67950	4	REVISION OF EYELID
67961	5	REVISION OF EYELID
67966	5	REVISION OF EYELID
67971	5	RECONSTRUCTION OF EYELID
67973	5	RECONSTRUCTION OF EYELID
67974	5	RECONSTRUCTION OF EYELID
67975	5	RECONSTRUCTION OF EYELID
OCULAR ADNEXA - CONJUNCTIVA		
CPT SUBSECTION: EXCISION, DESTRUCTION		
68115	4	REMOVE EYELID LINING LESION
68130	4	REMOVE EYELID LINING LESION
CPT SUBSECTION: CONJUNCTIVOPLASTY		
68320	6	REVISE/GRAFT EYELID LINING
68325	6	REVISE/GRAFT EYELID LINING
68326	6	REVISE/GRAFT EYELID LINING
68328	6	REVISE/GRAFT EYELID LINING
68330	6	REVISE EYELID LINING
68335	6	REVISE/GRAFT EYELID LINING
68340	6	SEPARATE EYELID ADHESIONS

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EYE AND OCULAR ADNEXA (CONTINUED)

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
CPT SUBSECTION: OTHER PROCEDURES		
68360	4	REVISE EYELID LINING
68362	4	REVISE EYELID LINING
68371 ³	4	HARVEST EYE TISSUE, ALOGRAFT
OCULAR ADNEXA - LACRIMAL SYSTEM		
CPT SUBSECTION: EXCISION		
68500	5	REMOVAL OF TEAR GLAND
68505	5	PARTIAL REMOVAL, TEAR GLAND
68510	2	BIOPSY OF TEAR GLAND
68520	5	REMOVAL OF TEAR SAC
68525	2	BIOPSY OF TEAR SAC
68540	5	REMOVE TEAR GLAND LESION
68550	5	REMOVE TEAR GLAND LESION
CPT SUBSECTION: REPAIR		
68700	4	REPAIR TEAR DUCTS
68720	6	CREATE TEAR SAC DRAIN
68745	6	CREATE TEAR DUCT DRAIN
68750	6	CREATE TEAR DUCT DRAIN
68770	6	CLOSE TEAR SYSTEM FISTULA
CPT SUBSECTION: PROBING AND RELATED PROCEDURES		
68810	2	PROBE NASOLACRIMAL DUCT
68811	4	PROBE NASOLACRIMAL DUCT
68815	4	PROBE NASOLACRIMAL DUCT

AUDITORY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
EXTERNAL EAR		
CPT SUBSECTION: EXCISION		
69110	2	REMOVE EXTERNAL EAR, PARTIAL
69120	4	REMOVAL OF EXTERNAL EAR
69140	4	REMOVE EAR CANAL LESION(S)
69145	4	REMOVE EAR CANAL LESION(S)
69150	5	EXTENSIVE EAR CANAL SURGERY
CPT SUBSECTION: REMOVAL OF FOREIGN BODY		
69205	3	CLEAR OUTER EAR CANAL
CPT SUBSECTION: REPAIR		
69300	5	REVISE EXTERNAL EAR
69310	5	REBUILD OUTER EAR CANAL
69320	9	REBUILD OUTER EAR CANAL
MIDDLE EAR		
CPT SUBSECTION: INCISION		
69421	5	INCISION OF EARDRUM
69436	4	CREATE EARDRUM OPENING
69440	5	EXPLORATION OF MIDDLE EAR

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CHAPTER 9, ADDENDUM B

TRICARE-APPROVED AMBULATORY SURGERY PROCEDURES ON OR AFTER 11/01/2003

AUDITORY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
69450	2	EARDRUM REVISION
CPT SUBSECTION: EXCISION		
69501	9	MASTOIDECTOMY
69502	9	MASTOIDECTOMY
69505	9	REMOVE MASTOID STRUCTURES
69511	9	EXTENSIVE MASTOID SURGERY
69530	9	EXTENSIVE MASTOID SURGERY
69550	7	REMOVE EAR LESION
69552	9	REMOVE EAR LESION
CPT SUBSECTION: REPAIR		
69601	9	MASTOID SURGERY REVISION
69602	9	MASTOID SURGERY REVISION
69603	9	MASTOID SURGERY REVISION
69604	9	MASTOID SURGERY REVISION
69605	9	MASTOID SURGERY REVISION
69620	5	REPAIR OF EARDRUM
69631	10	REPAIR EARDRUM STRUCTURES
69632	7	REBUILD EARDRUM STRUCTURES
69633	7	REBUILD EARDRUM STRUCTURES
69635	9	REPAIR EARDRUM STRUCTURES
69636	9	REBUILD EARDRUM STRUCTURES
69637	9	REBUILD EARDRUM STRUCTURES
69641	9	REVISE MIDDLE EAR & MASTOID
69642	9	REVISE MIDDLE EAR & MASTOID
69643	9	REVISE MIDDLE EAR & MASTOID
69644	9	REVISE MIDDLE EAR & MASTOID
69645	9	REVISE MIDDLE EAR & MASTOID
69646	9	REVISE MIDDLE EAR & MASTOID
69650	9	RELEASE MIDDLE EAR BONE
69660	7	REVISE MIDDLE EAR BONE
69661	7	REVISE MIDDLE EAR BONE
69662	7	REVISE MIDDLE EAR BONE
69666	6	REPAIR MIDDLE EAR STRUCTURES
69667	6	REPAIR MIDDLE EAR STRUCTURES
69670	5	REMOVE MASTOID AIR CELLS
69676	5	REMOVE MIDDLE EAR NERVE
CPT SUBSECTION: OTHER PROCEDURES		
69700	5	CLOSE MASTOID FISTULA
69711	2	REMOVE/REPAIR HEARING AID
69714	10	IMPLANT TEMPLE BONE W/STIMUL
69715	10	TEMPLE BNE IMPLNT W/STIMULAT
69717	10	TEMPLE BONE IMPLANT REVISION
69718	10	REVISE TEMPLE BONE IMPLANT
69720	7	RELEASE FACIAL NERVE
69725 ⁴	7	RELEASE FACIAL NERVE
69740	7	REPAIR FACIAL NERVE
69745	7	REPAIR FACIAL NERVE

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CHAPTER 9, ADDENDUM B

TRICARE-APPROVED AMBULATORY SURGERY PROCEDURES ON OR AFTER 11/01/2003

AUDITORY SYSTEM

CPT CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION*
INNER EAR		
CPT SUBSECTION: INCISION, DESTRUCTION		
69801	7	INCISE INNER EAR
69802	9	INCISE INNER EAR
69805	9	EXPLORE INNER EAR
69806	9	EXPLORE INNER EAR
69820	7	ESTABLISH INNER EAR WINDOW
69840	7	REVISE INNER EAR WINDOW
CPT SUBSECTION: EXCISION		
69905	9	REMOVE INNER EAR
69910	9	REMOVE INNER EAR & MASTOID
69915	9	INCISE INNER EAR NERVE
CPT SUBSECTION: INSERTION		
69930	9	IMPLANT COCHLEAR DEVICE

HCPCS CODE	TRICARE PAYMENT GROUP	SHORT DESCRIPTION
G0105 ³	4	COLORECTAL SCRIN; HI RISK IND
G0121 ³	4	COLON CA SCRIN NOT HI RSK IND
G0260	2	INJ FOR SACROILLIAC JT ANESTH
G0392 ⁷	10	AV FISTULA OR GRAFT ARTERIAL
G0393 ⁷	10	AV FISTULA OR GRAFT VENOUS

Except as provided below, all procedures are effective as of November 1, 2003

- ¹ Code added for services performed on or after January 1, 2004.
- ² Code deleted for services performed on or after January 1, 2004.
- ³ Code added for services performed on or after November 1, 2005.
- ⁴ Code deleted for services performed on or after November 1, 2005.
- ⁵ Code added for services performed on or after January 1, 2006.
- ⁶ Code deleted for services performed on or after January 1, 2006.
- ⁷ Code added for services performed on or after January 1, 2007.
- ⁸ Code deleted for services performed on or after January 1, 2007.

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FREESTANDING AND HOSPITAL-BASED BIRTHING CENTER REIMBURSEMENT

ISSUE DATE: February 14, 1984

AUTHORITY: 32 CFR 199.6(b)(4)(xi)(A)(3) and 32 CFR 199.14(e)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. DESCRIPTION

A birthing center is a freestanding or institution affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

III. POLICY

A. A freestanding or institution affiliated birthing center may be considered for status as an authorized institutional provider.

B. Reimbursement for all-inclusive maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the TRICARE established all-inclusive rate or the billed charge.

C. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility. The rate includes physician services for routine consultation when certified nurse-midwife is the attending professional.

NOTE: The initial complete newborn examination by a pediatrician is not included in the Birthing Center all-inclusive fee and is to be cost-shared as a part of the maternity episode when performed within 72 hours of the delivery.

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CHAPTER 10, SECTION 1

FREESTANDING AND HOSPITAL-BASED BIRTHING CENTER REIMBURSEMENT

D. Claims for professional services and tests where the beneficiary has been screened but rejected for admission into the program, or where the woman has been admitted but is discharged from the birthing center program prior to delivery, should be priced as individual services and items, subject to current policies for obstetrical care professional services and reported as appropriate CPT¹ procedure code with place of service "25" for birthing center.

E. Extraordinary maternity care services (services in excess of the quantity or type usually associated with all-inclusive maternity care and childbirth service for a normal pregnancy) may be cost-shared as part of the birthing center maternity episode and paid as the lesser of the billed charge or the allowable charge when the service is determined to be otherwise authorized and medically necessary and appropriate.

F. Calculation of the TRICARE maximum allowable birthing center all-inclusive rate.

1. The TRICARE maximum allowable all-inclusive rate is equal to the sum of the Class 3 CHAMPUS Maximum Allowable Charge (CMAC) for total obstetrical care for a normal pregnancy and delivery (CPT¹ procedure code 59400) plus the TMA supplied non professional price component amount. TMA will supply each contractor with non professional price components for each state annually ([Chapter 10, Addendum A](#)) to be effective for the forthcoming fiscal year.

2. The maximum allowable all-inclusive rate shall be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update.

G. Claims processing.

1. The cost-share amount for birthing center claims is calculated using the ambulatory surgery cost-share formula.

2. Claims from birthing centers will be processed as outpatient hospital claims using revenue code 724 and the following CPT¹ procedure code with place of service "25" for birthing center.

59400 *Birthing Center, all-inclusive charge, complete*

3. Both the technical and professional components of usual tests are included in the all-inclusive rate.

H. Excluded services¹ when billed separately.

99071 *Patient education materials*
99078 *Group health education*

- END -

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Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

4. The items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median cost for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group. However, exceptions may be made to the 2 times rule “in unusual cases, such as low volume items and services.”

5. The prospective payment rate for each APC is calculated by multiplying the APC’s relative weight by the conversion factor.

6. A wage adjustment factor will be used to adjust the portion of the payment rate that is attributable to labor-related costs for relative differences in labor and non-labor-related costs across geographical regions.

7. Applicable deductible and/or cost-sharing/copayment amounts will be subtracted from the adjusted APC payment rate based on the eligibility status of the beneficiary at the time outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra, and Standard beneficiary categories). TRICARE will retain its current hospital outpatient deductibles, cost-sharing/copayment amounts and catastrophic loss protection under the OPPS.

NOTE: The ASC cost-sharing provision (i.e., assessment of a single copayment for both the professional and facility charge for a Prime beneficiary) will be adopted as long as it is administratively feasible. This will not apply to Extra and Standard beneficiaries since their cost-sharing is based on a percentage of the total bill. The copayment is based on site of service, except for CPT¹/HCPCS 36400-36416, 59020, 59025, and 59050, for venipuncture and fetal monitoring. Reference [Chapter 2, Section 1, paragraph I.B.5.e.](#) and [f.](#)

G. Reimbursement Hierarchy For Procedures Paid Outside The OPPS.

1. CMAC Facility Pricing Hierarchy (No Technical Component (TC) Modifier).

The following tables includes the list of rate columns on the CMAC file. The columns are number 1 through 6 by description. The pricing hierarchy for facility CMAC is 8, 6, 4, then 2.

COLUMN	DESCRIPTION
1	Non-facility CMAC for physician/LLP class
2	Facility CMAC for physician/LLP class
3	Non-facility CMAC for non-physician class
4	Facility CMAC for non-physician class
Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the physician class TC rate. Otherwise, if the Facility CMAC for non-physician class > 0, then pay the Facility CMAC for non-physician class. Otherwise, pay Facility CMAC for physician/LLP class.	

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COLUMN	DESCRIPTION
5	Physician class Professional Component (PC) rate
6	Physician class Technical Component (TC) rate
7	Non-physician class PC rate
8	Non-physician class TC rate
<p>Description: If non-physician TC > 0, then pay the non-physician TC. Otherwise, if the Physician class TC rate > 0, then pay the physician class TC rate. Otherwise, if the Facility CMAC for non-physician class > 0, then pay the Facility CMAC for non-physician class. Otherwise, pay Facility CMAC for physician/LLP class.</p>	

If there is no CMAC available, the contractor shall reimburse the procedure under DMEPOS.

2. DMEPOS. If there is no DMEPOS available, the contractor shall reimburse the procedure using state prevailings.

3. State Prevailing Rate. If there is no state prevailing rate available, the contractor shall reimburse the procedure based on billed charges.

H. Outpatient Code Editor (OCE).

1. The OCE with APC program edits patient data to help identify possible errors in coding and assigns APC numbers based on HCPCS codes for payment under the OPPTS. The OPPTS is an outpatient equivalent of the inpatient, DRG-based PPS. Like the inpatient system based on DRGs, each APC has a pre-established prospective payment amount associated with it. However, unlike the inpatient system that assigns a patient to a single DRG, multiple APCs can be assigned to one outpatient record. If a patient has multiple outpatient services during a single visit, the total payment for the visit is computed as the sum of the individual payments for each service. Updated versions of the OCE (MF cartridge) and data files CD, along with installation and user manuals, will be shipped from the developer to the contractors. The contractors will be required to replace the existing OCE with the updated OCE within 21 calendar days of receipt. See [Chapter 13, Addendum A1](#), for quarterly review/update process.

2. The OCE incorporates the National Correct Coding Initiatives (NCCI) edits used by the CMS to check for pairs of codes that should not be billed together for the same patient on the same day. Claims reimbursed under the OPPTS methodology are exempt from the claims auditing software referenced in [Chapter 1, Section 3](#).

3. Under certain circumstances (e.g., active duty claims), the contractor may override claims that are normally not payable.

4. CMS has agreed to the use of 900 series numbers (900-999) within the OCE for TRICARE specific edits.

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPSS Final Rule.

2. If no treatment is furnished, medical screening examinations would be billed with a low-level emergency department code.

F. HCPCS/Revenue Coding Required Under OPSS. Hospital outpatient departments should use the CMS 1450 UB-04 Editor as a guide for reporting HCPCS and revenue codes under the OPSS.

G. Treatment of Partial Hospitalization Services. Effective upon implementation of OPSS, hospital-based Partial Hospitalization Programs (PHPs) (psych and Substance Use Disorder Rehabilitation Facilities (SUDRFs)) will be reimbursed a **national** per diem **APC** payment under the OPSS. Freestanding PHPs (psych and SUDRFs) will continue to be reimbursed under the existing PHP per diem payment.

1. The National Quality Monitoring Contractor (NQMC) shall include in their authorized provider reports to the contractors additional data elements indicating whether the facility is a freestanding PHP (psych or SUDRF) or a hospital-based PHP (psych). The contractors shall identify hospital-based PHPs (SUDRFs) that are subject to the per diem payment under the OPSS.

2. Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in lieu of inpatient psychiatric care in a hospital outpatient department.

3. Services of physicians, clinical psychologists, Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs), and Physician Assistants (PAs) furnished to partial hospitalization patients will continue to be billed separately as professional services and are not considered to be partial hospitalization services, **as long as these providers are not employed by or contracted by the facility.**

4. Payment for PHP (psych) services represents the provider's overhead costs, support staff, and the services of Clinical Social Workers (CSWs) and Occupational Therapists (OTs), whose professional services are considered to be included in the PHP per diem rate. For SUDRFs, the costs of alcohol and addiction counselor services would also be included in the per diem.

a. Hospitals will not bill the contractor for the professional services furnished by CSWs, OTs, and alcohol and addiction counselors.

b. Rather, the hospital's costs associated with the services of CSWs, OTs, and alcohol and addiction counselors will continue to be billed to the contractor and paid through the PHP per diem rate.

5. Per diem is the unit of payment since it defines the structure and scheduling of partial hospitalization services. The established per diem represents the median hospital cost

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CHAPTER 13, SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPTS Final Rule.

of furnishing a day of partial hospitalization. The following are billing instructions for submission of partial hospitalization claims/services:

a. Hospitals are required to use HCPCS codes and report line item dates for their partial hospitalization services.

b. The following is a complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services or other mental health services outside partial hospitalization:

FIGURE 13-2-1 REVENUE AND HCPCS LEVEL I AND II CODES USED IN BILLING FOR PARTIAL HOSPITALIZATION SERVICES AND OTHER MENTAL HEALTH SERVICES OUTSIDE PARTIAL HOSPITALIZATION FOR CY 2003

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I ¹ AND II CODES
0250	Pharmacy	HCPCS code not required
0911	Psychiatric General Services	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899
0912	Partial Hospitalization Program - Less Intensive (Half-day PHP)	H0035
0913	Partial Hospitalization Program - Intensive (Full-day PHP)	H0037
0914	Individual Psychotherapy	90816- 90819, 90821- 90824, 90826-90829
0915	Group Therapy	90849, 90853, 90857
0916	Family Psychotherapy	90846, 90847, 90849
0918	Psychiatric Testing	96100, 96115, 96117

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c. To bill for partial hospitalization services under the hospital OPPTS, hospitals are to use the above HCPCS and revenue codes and are to report partial hospitalization services under bill type 013X, along with condition code 41 on the CMS 1450 UB-04 claim form.

d. The claim must include a mental health diagnosis and an authorization on file for each day of service, along with a designated "H" code (i.e., either H0035 for half-day PHP or H0037 for full-day PHP) and its accompanying revenue code, prior to assigning a full- or half-day partial hospitalization APC. Claims that do not meet the above criteria (e.g., claim filed without condition code 41, appropriate "H" coding - H0035 or H0037, and/or revenue code) will undergo further prepayment review to ensure that outpatient department mental health procedures do not exceed the full-day partial hospitalization per diem amount; i.e., the sum of the individual mental health APC amounts on any particular day does not exceed

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPSS Final Rule.

anchor to bone and the anchor breaks because the bone is too hard or must be replaced with a larger anchor to achieve a desirable result). In such instances, separate reimbursement will be provided for both devices. This situation does not extend to devices that result in failure or are found to be defective. For failed or defective devices, hospitals are advised to contact the vendor/manufacturer.

NOTE: This applies to transitional pass-through devices only and not to devices packaged into an APC.

(2) Kits - Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, codes for such kits have not been established. However, hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payment, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.

(3) Multiple units - Hospitals must bill for multiple units of items that qualify for transitional pass-through payments, when such items are used with a single procedure, by entering the number of units used on the bill.

(4) Reprocessed devices - Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with the enforcement guidance of the FDA relating to the reprocessing of devices applicable at the time the service is delivered.

f. Calculation of Transitional Pass-Through Payment for a Pass-Through Device.

(1) Device pass-through payment is calculated by applying the statewide CCR to the hospital's charges on the claim and subtracting any appropriate pass-through offset. Statewide CCRs are based on the geographical CBSA (two digit = rural, five digit = urban).

(2) The following are two examples of the device pass-through calculations, one incorporating a device offset amount applicable to CY 2003 and the other only applying the CCR (offsets set to \$0 for CY 2005).

(3) The offset adjustment is applied only when a pass-through device is billed in addition to the APC¹.

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Example #1 Transitional Pass-Through Payment Calculation with Offset:

Device: (C1884 - Embolization Protective System)

Device cost = Hospital charge converted to cost = \$1,200.00

Associated procedure: HCPCS Level I¹ code 92982 (APC0083)

Payment rate = \$3,289.42

Coinsurance amount = \$657.88 (standard active duty family member who has met his/her yearly deductible)

Total offset amount to be applied for each APC that contains device costs = \$802.06

NOTE: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to [paragraph III.B.4.f.\(4\)](#) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:

$\$1,200 - \$802.06 = \$397.94$

TRICARE program payment (before wage index adjustment) for APC 0083:

$\$3,289.42 - \$657.88 = \$2,631.54$

TRICARE payment for pass-through device C1884 = \$397.94

Beneficiary cost-share liability for APC 0083 = \$657.88

Total amount received by provider for APC 0083 and pass-through device C1884:

\$2,631.54	TRICARE program payment for HCPCS Level I ¹ code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I ¹ code 92982
<u>397.94</u>	Transitional pass-through payment for device
\$3,687.36	Total amount received by the provider

Example #2 Transitional Pass-Through Payment Calculation without Offset

Device: (C1884 - Embolization Protective System)

Device cost = Hospital charge converted to cost = \$1,500.00

Associated procedure: HCPCS Level I² code 92982 (APC0083)

Payment rate = \$3,289.42

Coinsurance amount = \$657.88 (standard active duty family member who has met his/her yearly deductible)

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

Total offset amount to be applied for each APC that contains device costs = \$0.

NOTE: The total offset from the device amount is wage-index adjusted and the multiple procedure discount factor is adjusted before it is subtracted from the device cost. (Refer to [paragraph III.B.4.f.\(4\)](#) for detailed application of discounting factors to offset amounts.) This example assumes a wage index of 1.0000.

Device cost adjusted by total offset amount:

$$\$1,500 - \$0 = \$1,500$$

TRICARE program payment (before wage index adjustment) for APC 0083:

$$\$3,289.42 - \$657.88 = \$2,631.54$$

TRICARE payment for pass-through device C1884 = \$1,500

Beneficiary cost-share liability for APC 0083 = \$657.88

Total amount received by provider for APC 0083 and pass-through device C1884:

\$2,631.54	TRICARE program payment for HCPCS Level I ² code 92982 when used with device code C1884
657.88	Beneficiary coinsurance amount for HCPCS Level I ² code 92982
<u>1,500.00</u>	Transitional pass-through payment for device
\$4,789.42	Total amount received by the provider

NOTE: Transitional payments for devices (SI=H) are not subject to beneficiary cost-sharing/copayments.

(4) Steps involved in applying multiple discounting factors to offset amounts prior to subtracting from the device cost.

STEP 1: For each APC with an offset multiply the offset by the discount percent (whether it is 50%, 75%, 100% or 200%) and the units of service.

$$(\text{Offset} \times \text{Discount Rate} \times \text{Units of Service})$$

STEP 2: Sum the products of Step 1.

STEP 3: Wage adjust the sum of the products calculated in Step 2.

$$(\text{Step 2 Amount} \times \text{Labor \%} \times \text{Wage Index}) + \text{Step 2 Amount} \times \text{Nonlabor \%}$$

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Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

STEP 4: If the units of service from the procedures with offsets are greater than the device units of service, then Step 3 is adjusted by device units divided by procedure offset units.

$$[(\text{Step 2 Amount} \times \text{Labor \%} \times \text{Wage Index}) + (\text{Step 2 Amount} \times \text{Nonlabor \%}) \times (\text{Device Units} \div \text{Offset Procedure Units})]$$

otherwise

$$(\text{Step 2 Amount} \times \text{Labor \%} \times \text{Wage Index}) \text{ Step 2 Amount} \times \text{Non-Labor \%}$$

EXAMPLE: If there are two procedures with offsets but only one device, then the final offset is reduced by 50%.

STEP 5: If there is only one line item with a device, then the amount calculated in Step 4 is subtracted from the line item charge adjusted to cost.

$$[\text{Step 4 Amount} - (\text{Line Item Charge} \times \text{State CCR})]$$

If there are multiple devices, then the amount from Step 4 is allocated to the line items with devices based on their charges.

$$(\text{Line Item Device Charge} \div \text{Sum of Device Charges})$$

C. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status.

1. Radiopharmaceuticals, drugs, and biologicals which do not have pass-through status, are paid in one of three ways:

- a. Packaged payment, or
- b. Separate payment (individual APCs), or
- c. Allowable charge.

2. The cost of drugs and radiopharmaceuticals are generally packaged into the APC payment rate for the procedure or treatment with which the products are usually furnished:

a. Hospitals do not receive separate payment for packaged items and supplies;
and

b. Hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or services.

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

3. Although diagnostic and therapeutic radiopharmaceutical agents are not classified as drugs or biologicals, separate payment has been established for them under the same packaging threshold policy that is applied to drugs and biologicals; i.e., the same adjustments will be applied to the median costs for radiopharmaceuticals that will apply to non-pass-through, separately paid drugs and biologicals.

D. Criteria for Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals.

1. Generally, the cost of drugs and radiopharmaceuticals are packaged into the APC payment rate for the procedure or treatment with which the products are usually furnished. However, packaging for certain drugs and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

2. Payments for drugs and radiopharmaceuticals are packaged into the APCs with which they are billed if the median cost per day for the drug or radiopharmaceutical is less than \$55. Separate APC payment is established for drugs and radiopharmaceuticals for which the median cost per day exceeds \$55.

3. An exception to the packaging rule is being made for injectable oral forms of antiemetics.

4. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged.

a. "Specified Covered Outpatient Drugs" Classification

(1) Special classification (i.e., "specified covered outpatient drug") is required for certain separately payable radiopharmaceutical agents and drugs or biologicals for which there are specifically mandated payments.

(2) A "specified covered outpatient drug" is a covered outpatient drug for which a separate APC exists and that is either a radiopharmaceutical agent or drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

(3) The following drugs and biologicals are designated exceptions to the "specified covered outpatient drugs" definition (i.e., not included within the designated category classification):

(a) A drug or biological for which payment was first made on or after January 1, 2003, under the transitional pass-through payment provision.

(b) A drug or biological for which a temporary HCPC code has been assigned.

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

(c) Orphan drugs.

b. Payment of Specified Outpatient Drugs, Biological, and Radiopharmaceuticals.

(1) Specified outpatient drugs and biologicals will be paid a combined rate of the ASP plus 6% which is reflective of the present hospital acquisition and overhead costs for separately payable drugs and biologicals under the OPPS.

(2) Since there is no ASP data for separately payable specified radiopharmaceuticals, reimbursement will be based on charges converted to costs. This is the best proxy for the average acquisition cost of a radiopharmaceutical until better alternative information/data sources become available; e.g., basing payments on mean costs derived from hospital claims or creating charge-based payment rates.

(3) The following payment methods will be employed for separately payable specified outpatient drugs, biologicals and radiopharmaceuticals whose HCPCS codes will be payable for the first time under OPPS but whose codes do not crosswalk to other HCPCS codes previously recognized under the OPPS:

(a) Payment will be based on ASP plus 6% in accordance with the ASP methodology used in the physician office setting.

(b) In the absence of ASP data, the Wholesale Acquisition Cost (WAC) will be used for the product to establish the initial payment rate. If the WAC is also unavailable, then payment will be calculated at 95% of the most recent Average Wholesale Prices (AWP).

c. Designated SI.

The HCPCS codes for the above three categories of "specified covered outpatient drugs" are designated with the SI "K" - non-pass-through drugs, biologicals, and radiopharmaceuticals paid under the hospital OPPS (APC Rate). Refer to TMA's OPPS web site at <http://www.tricare.mil/opps> for APC payment amounts of separately payable drugs, biologicals and radiopharmaceuticals.

5. Payment for New Drugs and Biologicals With HCPCS Codes and Without Pass-Through Application and Reference AWP or Hospital Claims Data.

a. New drugs and biologicals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals will be paid a rate that is equivalent to the payment they would receive in the physician office setting (i.e., the ASP plus 6%).

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

b. These new drugs and biologicals will be treated the same irrespective of whether pass-through status has been determined. SI "K" will be assigned to HCPCS codes for new drugs and biologicals for which pass-through applications have not been received.

6. Drugs and Biologicals Not Eligible for Pass-Through Status and Receiving Separate Nonpass-Through Payment.

a. Payment will be based on median costs derived from CY claims data for drugs and biologicals that have been:

(1) Separately paid since implementation of the OPPS under Medicare, but were not eligible for pass-through status; and

(2) Historically packaged with the procedures with which they were billed, even though their median cost per day was above the \$55 packaging threshold.

b. Payment based on median costs should be adequate for hospitals since these products are generally older or low-cost items.

7. Payment for New Drugs, Biologicals and Radiopharmaceuticals Before HCPCS Codes Are Assigned.

a. The following payment methodology will enable hospitals to begin billing for drugs and biologicals that are newly approved by the FDA and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup that could qualify them for pass-through payment under the OPPS:

(1) Hospitals should be instructed to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code C9399, "Unclassified Drug or Biological."

(2) When HCPCS code C9399 appears on the claim, the OCE suspends the claim for manual pricing by the contractor.

(3) The new drug, biological and/or radiopharmaceutical will be priced at 95% of its AWP using Red Book or an equivalent recognized compendium, and process the claim for payment.

(4) The above approach enables hospitals to bill and receive payment for a new drug, biological or radiopharmaceutical concurrent with its approval by the FDA.

b. Hospitals will discontinue billing C9399 and the NDC upon implementation of a HCPCS code, SI, and appropriate payment amount with the next quarterly OPPS update.

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Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPTS Final Rule.

E. Drug Administration Coding and Payment.

1. The following HCPCS Level I drug administration codes will be assigned to their respective APCs for payment:

FIGURE 13-3-4 CROSSWALK FROM HCPCS LEVEL I¹ CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	X	0353
90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	X	0359
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	X	0352
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0116
96402	Chemotherapy administration subcutaneous or intramuscular; hormonal anti-neoplastic	S	0116
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0116
96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0116
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0117
96420	Chemotherapy administration, intra-arterial; push technique	S	0116
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0117
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	A	--
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	S	0117
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0116
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0116
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0116
96521	Refilling and maintenance of portable pump	T	0125
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	T	0125
96523	Irrigation of implanted venous access device for drug delivery systems	N	--

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FIGURE 13-3-4 CROSSWALK FROM HCPCS LEVEL I¹ CODES FOR DRUG ADMINISTRATION TO DRUG ADMINISTRATION APCs (CONTINUED)

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S	0116
96549	Unlisted chemotherapy procedure	S	0116
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2. Only 20 of the 33 drug administration CPT codes are being adopted for billing and payment purposes under OPPS.

3. Six new HCPCS “C” codes are being used instead of the remaining 13 CPT codes not recognized under the OPPS. The following “C” codes (see Figure 13-3-5) are being adopted in an effort to minimize the administrative burden of adopting all 33 drug administrative CPT codes.

a. The “C” codes will permit straightforward billing of types of pushes for the first hour and then each additional hour of infusion or for each intravenous push.

b. The OCE logic will determine the appropriate payments to make for a single drug administration encounter in one day or multiple separate encounters in the same day.

FIGURE 13-3-5 OPPS DRUG ADMINISTRATION CODES

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
C8950	Intravenous infusion for therapy/diagnosis; up to 1 hour	S	0120
C8951	Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950)	N	--
C8952	Therapeutic, prophylactic or diagnostic injection; intravenous push	X	0359
C8953	Chemotherapy administration, intravenous; push technique	S	0116
C8954	Chemotherapy administration, intravenous; infusion technique, up to one hour	S	0117
C8955	Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954)	N	--
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4. The following non-chemotherapy HCPCS codes have also been created that are similar to CPT codes for initiation of prolonged chemotherapy infusion requiring a pump and pump maintenance and refilling codes so hospitals can bill for services when provided

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

to patients who require extended infusions for non-chemotherapy medications including drugs for pain (see Figure 13-3-6).

FIGURE 13-3-6 NON-CHEMOTHERAPY PROLONGED INFUSION CODES THAT REQUIRE A PUMP

HCPCS LEVEL I ¹ CODE	DESCRIPTION	SI	APC
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0120
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5. Packaged HCPCS Level I codes for drug administration should continue to be billed to ensure accurate payment in the future. These are bill changes for HCPCS Level I codes with SI = N that will be used as the basis for setting median costs for each drug administration HCPCS Level I code in the future.

6. HCPCS Level I³ codes 90772-90774 each represent an injection and as such, one unit of the code may be billed each time there is a separate injection that meets the definition of the code.

7. Drugs for which the median cost per day is greater than \$55 are paid separately and are not packaged into the payment for the drug administration. Separate payment for drugs with a median cost in excess of \$55 will result in more equitable payment for both the drugs and their administration.

F. Coding and Payment Policies for Drugs and Supplies.

1. Drug Coding.

a. Drugs for which separate payment is allowed are designated by SI “K” and must be reported using the appropriate HCPCS code.

b. Drugs that are reported without a HCPCS code will be packaged under the revenue center code, under OPSS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633.

c. Drugs billed using revenue code 636 (“Drugs requiring detailed coding”) require use of the appropriate HCPCS code, or they will be denied.

d. Reporting charges of packaged drugs is critical because packaged drug costs are used for calculating outlier payments and hospital costs for the procedure and service with which the drugs are used in the course of the annual OPSS updates.

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2. Payment for the Unused Portion of a Drug.

a. Once a drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, hospitals are encouraged to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a TRICARE patient, the provider may bill for the amount of the drug discarded, along with the amount administered.

b. In the event that a drug is ordered and reconstituted by the hospital's pharmacy, but not administered to the patient, payment will be made under OPPS.

EXAMPLE 1: Drug X is available only in a 100-unit size. A hospital schedules three patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to OPPS on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen, and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

EXAMPLE 2: An appropriate hospital staff member must administer 30 units of drug X to a patient, and it is not practical to schedule another patient for the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and does not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and OPPS pays for 100 units.

c. Coding for Supplies.

(1) Supplies that are an integral component of a procedure or treatment are not reported with a HCPCS code.

(2) Charges for such supplies are typically reflected either in the charges on the line for the HCPCS for the procedure, or on another line with a revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

(3) Hospitals should report drugs that are treated as supplies because they are an integral part of a procedure or treatment under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs.

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPTS Final Rule.

G. Orphan Drugs.

1. Continue to use the following criteria for identifying single indication orphan drugs that are used solely for orphan conditions:

a. The drug is designated as an orphan drug by the FDA and approved by the FDA for treatment of only one or more orphan condition(s).

b. The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

2. Twelve single indication orphan drugs have currently been identified as having met these criteria.

3. Payment Methodology.

a. Pay all 12 single indication orphan drugs at the rate of 88% of AWP or 106 of the ASP, whichever is higher.

b. However, for drugs where 106% of ASP would exceed 95% of AWP, payment would be capped at 95% of AWP, which is the upper limit allowed for sole source specified covered outpatient drugs.

H. Vaccines.

1. Hospitals will be paid for influenza, pneumococcal pneumonia and hepatitis B vaccines based on allowable charge methodology; i.e., will be paid the CMAC rate for these vaccines.

2. Separately payable vaccines other than influenza, pneumococcal pneumonia and hepatitis B will be paid under their own APC.

3. See [Figure 13-3-7](#) for vaccine administration codes and SIs.

FIGURE 13-3-7 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS

HCPCS LEVEL 1 ¹ CODE	DESCRIPTION	SI	APC
G0008	Influenza vaccine administration	X	0350
G0009	Pneumococcal vaccine administration	X	0350
G0010	Hepatitis B vaccine administration	N	--
90465	Immunization admin, under 8 yrs old, with counseling; first injection	N	--

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Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPSS Final Rule.

FIGURE 13-3-7 VACCINE ADMINISTRATION CODES AND STATUS INDICATORS (CONTINUED)

HCPCS LEVEL 1 ¹ CODE	DESCRIPTION	SI	APC
90466	Immunization admin, under 8 yrs old, with counseling; each additional injection	N	--
90467	Immunization admin, under 8 yrs old, with counseling; first intranasal or oral	N	--
90468	Immunization admin, under 8 yrs old, with counseling; each additional intranasal or oral	N	--
90471	Immunization admin, one vaccine injection	X	0353
90472	Immunization admin, each additional vaccine injections	X	0353
90473	Immunization admin, one vaccine by intranasal or oral	N	
90474	Immunization admin, each additional vaccine by intranasal or oral	N	--

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I. Payment Policy for Radiopharmaceuticals.

Separately paid radiopharmaceuticals are classified as “specified covered outpatient drugs” subject to the following packaging and payment provisions:

1. The threshold for the establishment of separate APCs for radiopharmaceuticals is \$55.
2. A radiopharmaceutical that is covered and furnished as part of covered outpatient department services for which a HCPCS code has not been assigned will be reimbursed an amount equal to 95% of its AWP.
3. Radiopharmaceuticals will be excluded from receiving outlier payments.
4. Applications will be accepted for pass-through status; however, in the event the manufacturer seeking pass-through status for a radiopharmaceutical does not submit data in accordance with the requirements specified for new drugs and biologicals, payment will be set for the new radiopharmaceutical as a “specified covered outpatient drug.”

J. Blood and Blood Products.

1. Since the OPSS was first implemented, separate payment has been made for blood and blood products in APCs rather than packaging them into payment for the procedures with which they were administered. The APCs for these products are intended to recover the costs of the products.
2. Administrative costs for the processing and storage specific to the transfused blood product are included in the APC payment, which is based on hospitals’ charges.

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3. Payment for the collection, processing, and storage of autologous blood, as described by HCPCS Level I⁴ code 86890 and used in transfusion, is made through APC 347 (Level III Transfusion Laboratory Procedures).

4. Payment rates for blood and blood products will be determined based on median costs. Refer to [Figure 13-3-8](#) for APC assignment of blood and blood product codes.

FIGURE 13-3-8 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9010		K	Whole blood for transfusion	0950
P9011		K	Split unit of blood	0967
P9012		K	Cryoprecipitate each unit	0952
P9016		K	RBC leukocytes reduced	0954
P9017		K	Plasma 1 donor frz w/in 8 hr	9508
P9019		K	Platelets, each unit	0957
P9020		K	Platelet rich plasma unit	0958
P9021		K	Red blood cells unit	0959
P9022		K	Washed red blood cells unit	0960
P9023		K	Frozen plasma, pooled, sd	0949
P9031		K	Platelets leukocytes reduced	1013
P9032		K	Platelets, irradiated	9500
P9033		K	Platelets leukoreduced irradiated	0968
P9034		K	Platelets, pheresis	9507
P9035		K	Platelets pheresis leukoreduced	9501
P9036		K	Platelet pheresis irradiated	9502
P9037		K	Platelet pheresis leukoreduced irradiated	1019
P9038		K	RBC irradiated	9505
P9039		K	RBC deglycerolized	9504
P9040		K	RBC leukoreduced irradiated	0969
P9043		K	Plasma protein fract, 5%, 50 ml	0956
P9044		K	Cryoprecipitate reduced plasma	1009
P9048		K	Granulocytes, pheresis unit	9506
P9051	C1010	K	Blood, L/R, CMV-NEG	1010
P9052	C1011	K	Platelets, HLA-m, L/R, unit	1011
P9053	C1015	K	Plt, pher, L/R, CMV, irradiated	1020
P9054	C1016	K	Blood, L/R, Froz/Degly/Washed	1016
P9055	C1017	K	Plt, Aph/Pher, L/R, CMV-Neg	1017
P9056	C1018	K	Blood, L/R, Irradiated	1018

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Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

FIGURE 13-3-8 ASSIGNMENT OF BLOOD AND BLOOD PRODUCT CODES (CONTINUED)

HCPCS	EXPIRED HCPCS	STATUS INDICATOR	DESCRIPTION	APC
P9057	C1020	K	RBC, frz/deg/wash, L/R irradiated	1021
P9058	C1021	K	RBC, L/R, CMV-Neg, irradiated	1022
P9059	C1022	K	Plasma, frz within 24 hours	0955
P9060	C9503	K	Fresh frozen plasma, ea unit	9503

K. Payment When Devices Are Replaced Without Cost or Where Credit for a Replacement Device is Furnished to the Hospital.

1. Payments will be reduced for selected APCs in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device. The amount of the reduction to the APC rate will be calculated in the same manner as the offset amount that would be applied if the implanted device assigned to the APC has pass-through status.

2. This permits equitable adjustments to the OPPS payments contingent on meeting all of the following criteria:

a. All procedures assigned to the selected APCs must require implantable devices that would be reported if device replacement procedures are performed;

b. The required devices must be surgically inserted or implanted devices that remain in the patient’s body after the conclusion of the procedures, at least temporarily; and

c. The offset percent for the APC (i.e., the median cost of the APC without device costs divided by the median cost of the APC with device costs) must be significant--significant offset percent is defined as exceeding 40%.

3. The presence of the modifier “FB” [“Item Provided Without Cost to Provider, Supplier, or Practitioner or Credit Received for Replacement (examples include, but are not limited to devices covered under warranty, replaced due to defect, or provided as free samples)”] would trigger the adjustment in payment if the procedure code to which modifier “FB” was amended appeared in [Figure 13-3-9](#) and was also assigned to one of the APCs listed in [Figure 13-3-10](#).

FIGURE 13-3-9 DEVICES FOR WHICH THE “FB” MODIFIER MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL CREDIT FOR A REPLACEMENT DEVICE

DEVICE	DESCRIPTION
C1721	AICD, dual chamber
C1722	AICS, single chamber
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp

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FIGURE 13-3-9 DEVICES FOR WHICH THE “FB” MODIFIER MUST BE REPORTED WITH THE PROCEDURE WHEN FURNISHED WITHOUT COST OR AT FULL CREDIT FOR A REPLACEMENT DEVICE

DEVICE	DESCRIPTION
C1771	Rep Dev urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual rate-resp
C1786	Pmkr, single rate-resp
C1813	Prostheses, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro, rechg bat sys
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Pmkr, other than sing/dual
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8614	Cochlear device/system

FIGURE 13-3-10 ADJUSTMENTS TO APCs IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED

APC	SI	APC GROUP TITLE	CY 2007 OFFSET AMT (PERCENT)
0039	S	Level I Implantation of Neurostimulator	78.85
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	54.06
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluded	60.06
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	77.11
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	74.74

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Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

FIGURE 13-3-10 ADJUSTMENTS TO APCs IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED (CONTINUED)

APC	SI	APC GROUP TITLE	CY 2007 OFFSET AMT (PERCENT)
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	41.88
0107	T	Insertion of Cardioverter-Defibrillator	90.44
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	77.75
0222	T	Implantation of Neurological Device	77.65
0225	S	Implantation of Neurostimulator Electrodes, Cranial	79.04
0227	T	Implantation of Drug Infusion Devices	80.27
0229	T	Transcatheter Placement of Intravascular Shunts	46.17
0259	T	Level IV ENT Procedures	84.61
0315	T	Level II Implantation of Neurostimulator	76.03
0385	S	Level I Prosthetic Urological Procedures	83.19
0386	S	Level II Prosthetic Urological Procedures	61.16
0418	T	Insertion of Left Ventricular Pacing Elect	87.32
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker	77.35
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker	76.59
0680	S	Insertion of Patient Activated Event Recorders	76.40
0681	T	Knee Arthroplasty	73.37

4. If the APC to which the device code (i.e., one of the codes in [Figure 13-3-9](#)) is assigned is on the APCs listed in [Figure 13-3-10](#), the unadjusted payment rate for the procedure APC will be reduced by an amount equal to the percent in [Figure 13-3-10](#) times the unadjusted payment rate.

5. In cases in which the device is being replaced without cost, the hospital will report a token device charge. However, if the device is being inserted as an upgrade, the hospital will report the difference between its usual charge for the device being replaced and the credit for the replacement device.

6. Multiple procedure reductions would also continue to apply even after the APC payment adjustment to remove payment for the device cost, because there would still be the expected efficiencies in performing the procedure if it was provided in the same operative session as another surgical procedure. Similarly, if the procedure was interrupted before administration of anesthesia (i.e., there was modifier 52 or 73 on the same line as the procedure), a 50% reduction would be taken from the adjusted amount.

L. Policies Affecting Payment of New Technology Services.

1. A process was developed that recognizes new technologies that do not otherwise meet the definition of current orphan drugs, or current cancer therapy drugs and biologicals

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and brachytherapy, or current radiopharmaceutical drugs and biologicals products. This process, along with transitional pass-throughs, provides additional payment for a significant share of new technologies.

2. Special APC groups were created to accommodate payment for new technology services. In contrast to the other APC groups, the new technology APC groups did not take into account clinical aspects of the services they were to contain, but only their costs.

3. The SI "K" is used to denote the APCs for drugs, biologicals and pharmaceuticals that are paid separately from, and in addition to, the procedure or treatment with which they are associated, yet are not eligible for transitional pass-through payment.

4. New items and services will be assigned to these new technology APCs when it is determined that they cannot appropriately be placed into existing APC groups. The new technology APC groups provide a mechanism for initiating payment at an appropriate level within a relatively short time frame.

5. As in the case of items qualifying for the transitional pass-through payment, placement in a new technology APC will be temporary. After information is gained about actual hospital costs incurred to furnish a new technology service, it will be moved to a clinically-related APC group with comparable resource costs.

6. If a new technology service cannot be moved to an existing APC because it is dissimilar clinically and with respect to resource costs from all other APCs, a separate APC will be created for such services.

7. Movement from a new technology APC to a clinically-related APC will occur as part of the annual update of APC groups.

8. The new technology APC groups have established payment rates for the APC groups based on the midpoint of ranges of possible costs; for example, the payment amount for a new technology group reflecting a range of costs from \$300 to \$500 would be set at \$400. The cost range for the groups reflects current cost distributions, and TRICARE reserves the right to modify the ranges as it gains experience under the OPPS.

9. There are two parallel series of technology APCs covering a range of costs from less than \$50 to \$6,000.

a. The two parallel sets of technology APCs are used to distinguish between those new technology services designated with a SI of "S" and those designated as "T". These APCs allow assignment to the same APC group procedures that are appropriately subject to a multiple procedure payment reduction (T) with those that should not be discounted (S).

b. Each set of technology APC groups have identical group titles and payment rates, but a different SI.

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c. The new series of APC numbers allow for the narrowing of the cost bands and flexibility in creating additional bands as future needs may dictate. Following are the narrowed incremental cost bands for the two series of new technology APCs:

- (1) From \$0 to \$50 in increments of \$10.
- (2) From \$50 to \$100 in a single \$50 increment.
- (3) From \$100 through \$2,000 in intervals of \$100.
- (4) From \$2,000 through \$6,000 in intervals of \$500.

10. Beneficiary cost-sharing/copayment amounts for items and services in the new technology APC groups are dependent on the eligibility status of the beneficiary at the time the outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra and Standard beneficiary categories). (Refer to [Chapter 2, Addendum A](#) for applicable deductible cost-sharing/copayment amounts for outpatient hospital services.)

11. Process and Criteria for Assignment to a New Technology APC Group.

a. Services Paid Under New Technology APCs.

(1) Limit eligibility for placement in new technology APCs to complete services and procedures.

(2) Items, material, supplies, apparatuses, instruments, implements, or equipment that are used to accomplish a more comprehensive service or procedure would not be eligible for placement in a new technology APC.

(3) A service that qualifies for a new technology APC may be a complete, stand-alone service (for example, water-induced thermotherapy of the prostate or cryosurgery of the prostate), or it may be a service that would always be billed in combination with other services (for example, coronary artery brachytherapy).

(a) In the latter case, the new technology procedure, even though billed in combination with other, previously existing procedures, describes a distinct procedure with a beginning, middle, and end.

(b) Drugs, supplies, devices, and equipment in and of themselves are not distinct procedures with a beginning, middle and end. Rather drugs, supplies, devices, and equipment are used in the performance of a procedure.

(4) Unbundled components that are integral to a service or procedure (for example, preparing a patient for surgery or preparation and application of a wound dressing for wound care) are not eligible for consideration for a new technology.

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b. Criteria for determining whether a service will be assigned to a new technology APC.

(1) The most important criterion in determining whether a technology is “truly new” and appropriate for a new APC is the inability to appropriately, and without redundancy, describe the new, complete (or comprehensive) service with any combination of existing HCPCS Level I and II codes. In other words, a “truly new” service is one that cannot be appropriately described by existing HCPCS codes, and a new HCPCS code needs to be established in order to describe the new procedure.

(2) The service is one that could not have been adequately represented in the claims data being used for the most current annual payment update; i.e., the item is one service that could not have been billed to the Medicare program in 1996 or, if it was available in 1996, the costs of the service could not have been adequately represented in 1996 data.

(3) The service does not qualify for an additional payment under the transitional pass-through provisions.

(4) The service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs. It is unnecessary to assign a new service to a new technology APC if it may be appropriately placed in a current APC.

(5) The service falls within the scope of TRICARE benefits.

(6) The service is determined to be reasonable and necessary.

NOTE: The criterion that the service must have a HCPCS code in order to be assigned to a new technology APC has been removed. This is supported by the rationale that in order to be considered for a new technology APC, a truly new service cannot be adequately described by existing codes. Therefore, in the absence of an appropriate HCPCS code, a new HCPCS code will be created that describes the new technology service. The new HCPCS would be solely for hospitals to use when billing under the OPPS.

M. Coding And Payment Of Emergency Department (ED) Visits.

1. The five Type B ED “G” codes listed in [Figure 13-3-11](#) have been established for EDs meeting the definition of a dedicated emergency department (DED) under the Emergency Medical Treatment and Labor Act (EMTALA) regulations, but which are not Type A EDs (i.e., they may meet the DED definition but are not available 24 hours a day, seven days a week).

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FIGURE 13-3-11 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDs

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0380	Level 1 Hosp Type B Visit	Level 1 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0381	Level 2 Hosp Type B Visit	Level 2 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0382	Level 3 Hosp Type B Visit	Level 3 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)
G0384	Level 4 Hosp Type B Visit	Level 4 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)

Note: This reimbursement system is tentatively scheduled to become effective upon publication of the OPPS Final Rule.

FIGURE 13-3-11 FINAL HCPCS CODES TO BE USED TO REPORT ED VISITS PROVIDED IN TYPE B EDs (CONTINUED)

HCPCS CODE	SHORT DESCRIPTOR	LONG DESCRIPTOR
G0385	Level 5 Hosp Type B Visit	Level 5 hospital ED visit provided in a Type B ED. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or ED; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.)

2. A new “G” code (G0390 - Trauma response team activation associated with hospital critical care services) was also created (effective January 1, 2007) to be used in addition to CPT⁵ procedure codes 99291 and 99292 to address the meaningful cost difference between critical care when billed with and without trauma activation.

a. If critical care is provided without trauma activation, the hospital will bill with either CPT⁵ procedure code 99291 or 99292, receiving payment for APC 0617 with a median cost of \$402.67.

b. However if trauma activation occurs, the hospital would be called to bill one unit of “G” code (G0390), report with revenue code 68x on the same date of service, thereby receiving \$491.66 under APC 0618.

3. Hospitals will continue to bill CPT codes for both clinic and Type A ED visits until national guidelines have been established.

4. The CPT Evaluation and Management (E/M) codes and other HCPCS codes currently assigned to the clinic visit APCs have been mapped in [Figure 13-3-12](#) to 11 new APCs; five for clinic visits; five for ED visits; and one for critical care services, based on median costs and clinical consideration.

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FIGURE 13-3-12 ASSIGNMENT OF CPT E/M CODES AND OTHER HCPCS CODES TO NEW VISIT APCs FOR CY 2007

APC TITLE	APC	HCPCS	SHORT DESCRIPTOR
Level 1 Hospital Clinic Visits	0604	92012	Eye exam, established pat
		99201	Office/outpatient visit, new (Level 1)
		99211	Office/outpatient visit, est (Level 1)
		G0101	CA screen; pelvic/breast exam
		G0245	Initial foot exam Pt lops
		G0241	Office consultation (Level 1)
		G0271	Confirmatory consultation (Level 1)
		G0264	Assmt otr CHF, CP, asthma
Level 2 Hospital Clinic Visits	0605	92002	Eye exam, new patient
		92014	Eye exam and treatment
		99202	Office/outpatient visit, new (Level 2)
		99212	Office/outpatient visit, est (Level 2)
		99213	Office/outpatient visit, est (Level 3)
		99243	Office consultation (Level 3)
		99242	Office consultation (Level 2)
		99273	Confirmatory consultation (Level 3)
		99272	Confirmatory consultation (Level 2)
		99431	Initial care, normal newborn
		G0246	Follow-up eval of foot pt lop
		G0344	Initial preventive exam
Level 3 Hospital Clinic Visits	0606	92004	Eye exam, new patient
		99203	Office/outpatient visit, new (Level 3)
		99214	Office/outpatient visit, est (Level 4)
		99274	Confirmatory consultation (Level 4)
		99244	Office consultation (Level 4)
Level 4 Hospital Clinic Visits	0607	99204	Confirmatory consultation (Level 1)
		99215	Office/outpatient visit, est (Level 5)
		99245	Office consultation (Level 5)
		99275	Confirmatory consultation (Level 5)
Level 5 Hospital Clinic Visits	0608	99205	Office/outpatient visit, new (Level 5)
		G0175	OPPS service, sched team conf
Level 1 Type A Emergency Visits	0609	99281	Emergency department visit
Level 2 Type A Emergency Visits	0613	99282	Emergency department visit
Level 3 Type A Emergency Visits	0614	99283	Emergency department visit
Level 4 Type A Emergency Visits	0615	99284	Emergency department visit
Level 5 Type A Emergency Visits	0616	99285	Emergency department visit
Critical Care	0617	99291	Critical care, first hour

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N. OPPS PRICER.

1. Common PRICER software will be provided to the contractor that includes the following data sources:

- a. National APC amounts
- b. Payment status by HCPCS code
- c. Multiple surgical procedure discounts
- d. Fixed dollar threshold
- e. Multiplier threshold
- f. Device offsets
- g. Other payment systems pricing files (CMAC, DMEPOS, and statewide prevailings)

2. The following data elements will be extracted and forwarded to the outpatient PRICER for line item pricing.

- a. Units;
- b. HCPCS/Modifiers;
- c. APC;
- d. Status payment indicator;
- e. Line item date of service;
- f. Primary diagnosis code; and
- g. Other necessary OCE output.

3. The following data elements will be passed into the PRICER by the contractors:

- a. Wage indexes (same as DRG wage indexes);
- b. Statewide cost-to-charge ratios as provided in CMS Final Rule;
- c. Locality Code: Based on CBSA - two digit = rural and five digit = urban;
- d. Hospital Type: Rural SCH = 1 and All Others = 0

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4. The outpatient PRICER will return the line item APC and cost outlier pricing information used in final payment calculation. This information will be reflected in the provider remittance notice and beneficiary Explanation of Benefits (EOB) with exception for an electronic 835 transaction. Paper EOBs and remits will reflect APCs at the line level and will also include indication of outlier payments and pricing information for those services reimbursed under other than OPSS methodology's, e.g., CMAC (SI = A) when applicable.

5. If a claim has more than one service with a SI of "T" or a SI of "S" within the coding range of 10000 - 69999, and any lines with SI of "T" or a SI within the coding range of 10000 - 69999 have less than \$1.01 as charges, charges for all lines will be summed and the charges will then be divided up proportionately to the payment rates for each line (refer to [Figure 13-3-13](#)). The new charge amount will be used in place of the submitted charge amount in the line item outlier calculator.

FIGURE 13-3-13 PROPORTIONAL PAYMENT FOR "T" LINE ITEMS

SI	CHARGES	PAYMENT RATE	NEW CHARGES AMOUNT
T	\$19,999	\$6,000	\$12,000
T	\$1	\$3,000	\$6,000
T	\$0	\$1,000	\$2,000
Total	\$20,000	\$10,000	\$20,000

NOTE: Because total charges here are \$20,000 and the first SI of "T" gets \$6,000 of the \$10,000 total payment, the new charge for that line is $\$6,000/\$10,000 \times \$20,000 = \$12,000$.

O. TRICARE Specific Procedures/Services.

1. TRICARE specific APCs have been assigned for half-day PHPs.
2. Other procedures that are normally covered under TRICARE but not under Medicare will be assigned SI of "A" (i.e., services that are paid under some payment method other than OPSS) until they can be placed into existing or new APC groups.

P. Validation Reviews.

OPSS claims are not subject to validation review.

Q. Hospital-Based Birthing Centers.

Hospital-based birthing centers will be reimbursed the same as freestanding birthing centers except the all inclusive rate consisting of the CMAC for procedure code 59400 and the state specific non-professional component, will lag two months (i.e., April 1 instead of February 1).

- END -

