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DEFENSE
HEALTH AGENCY

HPOD

CHANGE 214
6010.57-M
DECEMBER 3, 2018

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

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

CHANGE TITLE: **EVOLVING PRACTICES 18-004**

CONREQ: 19819

SUMMARY OF CHANGE(S): See page 2.

EFFECTIVE DATE: See page 2.

IMPLEMENTATION DATE: January 4, 2019.

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

SUMMARY OF CHANGES

CHAPTER 4

1. Section 6.1. This change adds coverage of open, arthroscopic and combined surgery for the treatment of Femoroacetabular Impingement (FAI) under the TRICARE Basic Program. EFFECTIVE DATE: 05/04/2017.

CHAPTER 5

2. Section 1.1. This change adds TRICARE coverage for Magnetic Resonance Spectroscopy (MRS) for the diagnosis of brain tumors and differentiation of necrosis and tumor progression. EFFECTIVE DATE: 01/15/2016.

Chapter 4 Section 6.1

Musculoskeletal System

Issue Date: August 26, 1985
Authority: 32 CFR 199.4(c)(2) and (c)(3)

1.0 CPT[1] PROCEDURE CODES

20005 - 20551, 20555 - 22328, 22510 - 22515, 22532 - 22856, 22858, 22859, 22861, 22864 - 27138, 27140, 27146 - 27179, 27181 - 29862, 29870 - 29916, 29999

2.0 HCPCS CODES

S2112, S2118, S2325

3.0 DESCRIPTION

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

4.0 POLICY

4.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered. U.S. Food and Drug Administration (FDA) approved surgically implanted devices are also covered.

4.2 Autologous cultured chondrocytes on porcine collagen membrane (i.e., Matrix-Induced Autologous Chondrocyte Implantation [MACI]) to treat cartilage defects of the knee is proven.

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

4.4 Percutaneous vertebroplasty (CPT[1] procedure codes 22510-22512) and balloon kyphoplasty (CPT[1] procedure codes 22513-22515) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

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

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

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4.7 Single-level, cervical Total Disc Replacement (cTDR) (CPT[2] procedure code 22856) and two-level, cervical TDR (CPT[2] procedure code 22858) using an FDA approved cervical artificial intervertebral disc for the treatment of cervical Degenerative Disc Disease (DDD), intractable radiculopathy, and/or myelopathy is covered if the disc is used in accordance with its FDA labeled indications.

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

- Patients have chronic plantar fasciitis of at least six months duration;
- Patients have undergone and failed six months of appropriate conservative therapy; and
- HE ESWT is defined as Energy Flux Density (EFD) greater than 0.12 millijoules per square millimeter (mJ/mm2).

4.9 Meniscal allograft transplant of the knee is covered.

4.10 Hip resurfacing (CPT[2] procedure codes 27125 and 27130, and HCPCS S2118) with an FDA approved device is proven for the treatment of Degenerative Joint Disease (DJD) of the hip in patients who are less than 65 years old and who meet all of the following criteria:

- Have chronic, persistent pain and/or disability;
- Are otherwise healthy and active;
- Have normal proximal femoral bone geometry and bone quality; and
- Would otherwise receive a conventional Total Hip Replacement (THR), but are likely to outlive a conventional THR implant system's expected life.

4.11 Minimally Invasive Surgery (CPT[2] procedure code 27279) for treatment of sacroiliac joint pain is proven.

4.12 Autologous Chondrocyte Implantation (ACI), with Carticel, for the repair of patellar cartilage lesions is proven.

4.13 Single-level, lumbar TDR (CPT[2] procedure code 22857) using an FDA approved lumbar artificial intervertebral disc for the treatment of single-level, lumbar DDD in patients who have failed conservative treatment is covered if the disc is used in accordance with its FDA labeled indications.

4.14 Open, arthroscopic, and combined hip surgery (CPT[2] 27140, 27179, 29862, 29914 - 29916) for the treatment of Femoroacetabular Impingement (FAI) is proven and covered when all of the following criteria are met:

- Moderate to severe and persistent activity limiting hip pain that is worsened by flexion

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activities.

- Physical examination consistent with the diagnosis of FAI with at least one positive test required:
  - Positive impingement sign (pain when bringing the knee up towards the chest and then rotating it inward towards the opposite shoulder); or
  - Flexion Abduction External Rotation (FABER) provocation test (the test is positive if it elicits similar pain as complained by the patient or the range of motion of the hip is significantly decreased compared to the contra lateral hip); or
  - Posterior inferior impingement test (the test is positive if it elicits similar pain as complained by the patient).
- Failure to improve with greater than three months of conservative treatment (e.g., physical therapy, activity modification, non-steroidal anti-inflammatory medications, intra-articular injection, etc.); and
- Radiographic evidence of FAI; and
- Absence of advanced arthritis.

5.0 EXCLUSIONS

5.1 Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.

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

5.3 Trigger point injection (CPT[3] procedure codes 20552 and 20553) for migraine headaches.

5.4 Cervical TDR, three or more levels (CPT[3] procedure code 0375T), is unproven.

5.5 Removal of cervical TDR, three or more levels (CPT[3] procedure code 0095T), is unproven. Also, see Section 1.1.

5.6 Lumbar TDR, two or more levels (CPT[3] procedure codes 0163T and 0165T), is unproven.

5.7 Removal of lumbar TDR, each additional level (CPT[3] procedure code 0164T), is unproven.

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

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

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

5.11 Thermal Intradiscal Procedures (TIPs) (CPT[4] procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (IDTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as Percutaneous Radiofrequency (RF) Thermomodulation or Percutaneous Plasma Diskectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

5.12 Spinal manipulation under anesthesia (CPT[4] procedure codes 00640 and 22505) for the treatment of back pain is unproven.

5.13 Minimally Invasive Lumbar Decompression (mild®) for the treatment of DDD and/or spinal stenosis is unproven.

5.14 Athletic pubalgia surgery is unproven.

6.0 EFFECTIVE DATES

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

6.2 May 1, 2008, for TAR.

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

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

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

6.6 May 1, 2015, for meniscal allograft transplant of the knee.

6.7 May 21, 2014, for hip resurfacing for treatment of DJD of the hip.

6.8 July 27, 2015, for two-level cervical TDR using an FDA approved cervical artificial intervertebral disc.

6.9 August 23, 2016, Minimally Invasive Surgery (CPT[4] procedure code 27279) for the treatment of sacroiliac joint pain is proven.

6.10 May 7, 2016, for ACI surgery, with Carticel, for the repair of patellar cartilage lesions.

6.11 December 13, 2016, for autologous cultured chondrocytes on porcine collagen membrane.

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6.12 November 16, 2017, for single-level, lumbar TDR using an FDA approved lumbar artificial intervertebral disc.

6.13 May 4, 2017, for open, arthroscopic, and combined hip surgery for the treatment of FAI.

- END -

3.12.3 When medically necessary and appropriate.

3.12.4 Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors for osteoporosis are those identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG).

3.13 Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT[4] procedure code 72291) or under CT guidance (CPT[4] procedure code 72292) is covered.

3.14 Multislice or multidetector row CT angiography (CT, heart) (CPT[4] codes 75571 - 75574) is covered for the following indications:

3.14.1 Evaluation of heart failure of unknown origin when invasive coronary angiography +/- Percutaneous Coronary Intervention (PCI) is not planned, unable to be performed or is equivocal.

3.14.2 In an Emergency Department (ED) for patients with acute chest pain, but no other evidence of cardiac disease (low-pretest probability), when results would be used to determine the need for further testing or observation.

3.14.3 Acute chest pain or unstable angina when invasive coronary angiography or a PCI cannot be performed or is equivocal.

3.14.4 Chronic stable angina and chest pain of uncertain etiology or other cardiac findings prompting evaluation for CAD (for example: new or unexplained heart failure or new bundle branch block).

3.14.4.1 When invasive coronary angiography or PCI is not planned, unable to be performed, or is equivocal; AND

3.14.4.2 Exercise stress test is unable to be performed or is equivocal; AND

3.14.4.3 At least one of the following non-invasive tests were attempted and results could not be interpreted or where equivocal or none of the following tests could be performed:

3.14.4.3.1 Exercise stress echocardiography.

3.14.4.3.2 Exercise stress echo with dobutamine.

3.14.4.3.3 Exercise myocardial perfusion (SPECT).

3.14.4.3.4 Pharmacologic myocardial perfusion (SPECT).

3.14.5 Evaluation of anomalous native coronary arteries in symptomatic patients when conventional angiography is unsuccessful or equivocal and when results would impact treatment.

3.14.6 Evaluation of complex congenital anomaly of coronary circulation or of the great vessels.

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3.14.7 Presurgical evaluation prior to biventricular pacemaker placement.

3.14.8 Presurgical evaluation of coronary anatomy prior to non-coronary surgery (valve placement or repair; repair of aortic aneurysm or dissection).

3.14.9 Presurgical cardiovascular evaluation for patients with equivocal stress study prior to kidney or liver transplantation.

3.14.10 Presurgical evaluation prior to electrophysiologic procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

3.14.11 CT angiography for acute ischemic stroke (CPT[5] codes 70496 and 70498) are proven when medically necessary and appropriate.

3.14.12 CT angiography for intracerebral aneurysm and subarachnoid hemorrhage (CPT[5] codes 70496 and 70498) are proven when medically necessary and appropriate.

3.15 Transient elastography (TE) (ultrasound-based transient elastography or FibroScan®) (CPT[5] procedure codes 0346T and 91200) for the detection and monitoring of hepatic cirrhosis in patients with chronic hepatitis C is covered.

3.16 Magnetic Resonance Spectroscopy (MRS) (CPT[5] code 76390) is covered for the following indications:

- Distinguishing low grade from high grade gliomas;
- Evaluating a brain lesion of indeterminate nature when MRS findings will impact the medical management of the patient;
- Distinguishing recurrent brain tumor from radiation-induced tumor necrosis.

4.0 EXCLUSIONS

4.1 Bone density studies for the routine screening of osteoporosis.

4.2 Ultrafast CT (electron beam CT (HCPCS code S8092)) to predict asymptomatic heart disease is preventive. Ultrafast CT (electron beam CT) is excluded for symptomatic patients and for screening asymptomatic patients for CAD.

4.3 MRIs (CPT[5] procedure codes 77058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.

4.4 MRIs (CPT[5] procedure codes 76058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.

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4.5 3D rendering (CPT[6] procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

4.6 3D rendering (CPT[6] procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

4.7 3D rendering (CPT[6] procedure codes 76376 and 76377) for use as a screening test for CAD in healthy individuals or in asymptomatic patients who have one or more traditional risk factors for CAD is unproven.

4.8 CT, heart, without contrast material, with quantitative evaluation of coronary calcium (CPT[6] procedure code 75571) is excluded for patients with typical anginal chest pain with high suspicion of CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

4.9 CT, heart, without contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed) (CPT[6] procedure code 75572) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

4.10 CT, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed) (CPT[6] procedure code 75573) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

4.11 CT angiography heart, coronary arteries and bypass (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) (CPT[6] procedure code 75574) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

4.12 Multislice or multidetector row CT angiography of less than 16 slices per sec and 1 mm or less resolution is excluded.

4.13 Radiological supervision and interpretation of percutaneous vertebroplasty (CPT[6] procedure codes 72291 and 72292).

4.14 Computer-Aided Detection with breast MRI (CPT[6] 0159T) is unproven.

4.15 MRS of the brain is unproven with the exception of paragraph 3.16.

4.16 Digital Breast Tomosynthesis (DBT) (CPT[6] procedure codes 77061 and 77062) is unproven.

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5.0 EFFECTIVE DATES

5.1 The effective date for MRIs with contrast media is dependent on the U.S. Food and Drug Administration (FDA) approval of the contrast media and a determination by the contractor of whether the labeled or unlabeled use of the contrast media is medically necessary and a proven indication.

5.2 March 31, 2006, for breast MRI.

5.3 March 31, 2006, for coverage of multislice or multidetector row CT angiography.

5.4 January 1, 2007, for CPT[7] procedure codes 72291 and 72292.

5.5 January 1, 2007, for coverage of multislice of multidetector row CT angiography performed for presurgical evaluation prior to electrophysiological procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

5.6 October 1, 2008, for breast MRI for guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

5.7 October 3, 2006, for CMR.

5.8 December 9, 2014, for TE.

5.9 January 15, 2016, for MRS for distinguishing low grade from high grade gliomas, evaluating a brain lesion of indeterminate nature when MRS findings will impact the medical management of the patient, and distinguishing recurrent brain tumor from radiation-induced tumor necrosis.

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