

Musculoskeletal System

Issue Date: August 26, 1985

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

1.0 CPT¹ 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 microdiscectomy with allogeneic or autogeneic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

4.4 Percutaneous vertebroplasty (CPT¹ procedure codes 22510-22512) and balloon kyphoplasty (CPT¹ 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) (CPT¹ 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).

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

4.7 Single-level, cervical Total Disc Replacement (cTDR) (CPT² procedure code 22856) and two-level, cervical TDR (CPT² 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 (CPT² 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 (CPT² 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 (CPT² 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 (CPT² 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

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

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 (CPT³ procedure codes 20552 and 20553) for migraine headaches.

5.4 Cervical TDR, three or more levels (CPT³ procedure code 0375T), is unproven.

5.5 Removal of cervical TDR, three or more levels (CPT³ procedure code 0095T), is unproven. Also, see [Section 1.1](#).

5.6 Lumbar TDR, two or more levels (CPT³ procedure codes 0163T and 0165T), is unproven.

5.7 Removal of lumbar TDR, each additional level (CPT³ 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 (CPT³ procedure codes 0171T and 0172T, HCPCS code C1821) for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

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

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) (CPT⁴ procedure codes 22526, 22527, 62287, and Healthcare Common Procedure Coding System (HCPCS) code S2348) are unproven. TIPs are also known as: Intradiscal Electrothermal Annuloplasty (IEA), Intradiscal Electrothermal Therapy (IDET), Intradiscal Thermal Annuloplasty (IDTA), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Coblation Percutaneous Disc Decompression, Nucleoplasty (also known as Percutaneous Radiofrequency (RF) Thermomodulation or Percutaneous Plasma Discectomy), Radiofrequency Annuloplasty (RA), Intradiscal Biacuplasty (IDB), Percutaneous (or Plasma) Disc Decompression (PDD), Targeted Disc Decompression (TDD), Cervical Intradiscal RF Lesioning.

5.12 Spinal manipulation under anesthesia (CPT⁴ 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 (CPT⁴ procedure code 27279) for the treatment of sacroiliac joint pain is proven.

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

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

⁴ CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 4, Section 6.1

Musculoskeletal System

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 -

