

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

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I. POLICY

A. TRICARE Prime enrollees may receive Prime Clinical Preventive Services from any network provider without referral, authorization, or preauthorization from the Primary Care Manager (PCM), or any other authority. If a Prime Clinical Preventive Service is not available from a network provider (e.g., a network provider is not available within prescribed access parameters), an enrollee may receive the service from a non-network provider with a referral from the PCM and authorization from the contractor. If an enrollee uses a non-network provider without first obtaining a referral from the PCM and authorization from the Health Care Finder (HCF) payment is made under the Point of Service (POS) option only for services that are otherwise covered under TRICARE Standard. Payment will not be made under the POS option for clinical preventive services that are not otherwise covered under TRICARE Standard.

B. There shall be no co-payments associated with the individually TRICARE reimbursable services listed below. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the below listed CPT procedure code is individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race or clinical history perimeters included below. However, a 30 day administrative tolerance will be allowed for any time interval requirements imposed on screening **mammography** and Pap smears; e.g., if an asymptomatic woman 50 years of age or older received a screening mammography on September 15, coverage for another screening mammography would be allowed on or after August 17 of the following year.

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
COMPREHENSIVE HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	For ages 24 months or older: One comprehensive disease prevention clinical evaluation and follow up during age intervals: 2-4; 5-11; 12-17; 18-39; 40-64.	CPT ¹ codes 99382-99386 and 99392-99396.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
TARGETED HEALTH PROMOTION AND DISEASE PREVENTION EXAMINATIONS	The following screening examinations may be performed during either the above periodic comprehensive health promotion examination or as part of other patient encounters. The intent is to maximize preventive care.	
School Physicals:	Physical Examinations: For beneficiaries ages five through 11 that are required in connection with school enrollment. The effective date for coverage of school enrollment physicals is October 30, 2000.	CPT ¹ codes 99201-99205*, 99211-99214*, 99383, and 99393.
	* Standard office visit evaluation and management CPT ¹ procedure codes (i.e., code ranges 99201-99205 and 99211-99214) may be used in billing for school physicals; however, payment may not exceed what would have otherwise been reimbursed under the comprehensive preventive medicine service codes for beneficiaries ages five through 11 (CPT ¹ procedure codes 99383 and 99393).	
Breast Cancer:	Clinical Breast Examination (CBE): For women under age 40, CBE may be performed during a covered periodic preventive health exam. For women age 40 and older, CBE should be performed annually.	See appropriate level evaluation and management codes.
	Screening Mammography: Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors: 1. History of breast cancer, Ductal Carcinoma In Situ (DCIS), Lobular Carcinoma In Situ (LCIS), Atypical Ductal Hyperplasia (ADH), or Atypical Lobular Hyperplasia (ALH); 2. Extremely dense breasts when viewed by mammogram; 3. *Known BRCA1 or BRCA2 gene mutation; 4. *First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves; 5. Radiation therapy to the chest between the ages of 10 and 30 years; or	CPT ¹ codes 77052 and 77057 HCPCS codes G0202, G0204, and G0206.
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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Breast Cancer (Continued):	<p>Screening Mammography (Continued): 6. History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes.</p>	
	<p>* Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors here does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.</p>	
	<p>Breast Screening Magnetic Resonance Imaging (MRI): Covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:</p> <ol style="list-style-type: none"> 1. *Known BRCA1 or BRCA2 gene mutation; 2. * First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves; 3. Radiation to the chest between the ages of 10 and 30; or 4. History of LiFraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes. <p>The effective date for breast cancer screening MRI is March 1, 2007.</p>	CPT ¹ codes 77058 and 77059.
	<p>* Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors here does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.</p>	
Cancer of Female Reproductive Organs:	<p>Pelvic Examination: Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.</p>	See appropriate level evaluation and management codes.
	<p>Papanicolaou (PAP) Smears: Annually starting at age 18 (or younger, if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may then be less often at the discretion of the patient and clinician but not less frequently than every three years.</p>	CPT ¹ codes 88141-88155, 88164-88167, 88174, 88175, 99201-99215, or 99301-99313.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Cancer of Female Reproductive Organs (Continued):	<p>Human Papillomavirus (HPV) Deoxyribonucleic Acid (DNA) Testing: HPV DNA testing is covered as a cervical cancer screening only when performed in conjunction with a Pap smear, and only for women aged 30 and older.</p> <p>To be eligible for reimbursement as a cervical cancer screening, HPV DNA testing must be billed in conjunction with a Pap smear that is provided to a woman aged 30 or older.</p> <p>The effective date for coverage of HPV DNA testing as a cervical cancer screening is September 7, 2010.</p>	CPT ¹ codes 87620-87622.
Testicular Cancer:	Testicular Examination: Clinical testicular exam annually for males age 13-39 with a history of cryptorchidism, orchiopexy, or testicular atrophy.	See appropriate level evaluation and management codes.
Prostate Cancer:	Rectal Examination: Digital rectal examination should be offered annually for all men aged 50 years and over; men aged 45 and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	See appropriate level evaluation and management codes.
Prostate Cancer (Continued):	Prostate-Specific Antigen (PSA): Annually for the following categories of males: all men aged 50 years and older; men aged 45 years and over with a family history of prostate cancer in at least one other family member; all African American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.	CPT ¹ code 84153.
Colorectal Cancer:	<p>Fecal Occult Blood Testing for Individuals at Average Risk for Colon Cancer: Either guaiac-based or immunochemical-based testing of three consecutive stool samples once every 12 months for beneficiaries who have attained age 50 (at least 11 months must have passed following the month in which the last covered screening fecal-occult blood test was done).</p> <p>The effective date for coverage of guaiac-based testing is October 6, 1997. The effective date for coverage of immunochemical-based testing is August 20, 2003.</p>	CPT ¹ codes 82270 and 82274.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	<p>Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at <u>Average Risk</u> for Colon Cancer: Once every three to five years beginning at age 50.</p> <p>Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at <u>Increased</u> or <u>High Risk</u> for Colon Cancer:</p> <p><u>Increased Risk</u> (Individuals with a family history): Once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colorectal cancer.</p> <p><u>High Risk</u>: Annual flexible sigmoidoscopy, beginning at age 10 through 12, for individuals with known or suspected Familial Adenomatous Polyposis (FAP).</p> <p>The effective date for coverage of proctosigmoidoscopy or flexible sigmoidoscopy, regardless of risk, is October 6, 1997.</p>	<p>CPT¹ codes 45300-45321, 45327, and 45330-45339. HCPCS code G0104.</p>
	<p>Optical (Conventional) Colonoscopy for Individuals at <u>Average</u>, <u>Increased</u>, or <u>High Risk</u> for Colon Cancer:</p> <p><u>Average Risk</u>: Once every 10 years for individuals age 50 or above.</p> <p>The effective date for coverage of optical colonoscopy for individuals at average risk is March 15, 2006.</p> <p><u>Increased Risk (Individuals with a family history):</u></p> <ol style="list-style-type: none"> Once every five years for individuals with a first-degree relative diagnosed with sporadic colorectal cancer or an adenomatous polyp before the age of 60, or in two or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. Once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with sporadic colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second degree relatives. 	

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	<p>Optical (Conventional) Colonoscopy for Individuals at Average, Increased, or High Risk for Colon Cancer (Continued):</p> <p>High Risk:</p> <p>1. Once every one to two years for individuals with a genetic or clinical diagnosis of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20 to 25 or 10 years younger than the earliest age of diagnosis, whichever is earlier.</p> <p>2. For individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.</p> <p>The effective date for coverage of optical colonoscopy for individuals at increased or high risk, is October 6, 1997.</p>	<p>CPT¹ codes 45355 and 45378-45385. HCPCS codes G0105 and G0121.</p>
	<p>Computed Tomographic Colonography (CTC) for Individuals in whom an Optical Colonoscopy is Medically Contraindicated or Incomplete: CTC is covered as a colorectal cancer screening ONLY when an optical colonoscopy is medically contraindicated OR cannot be completed due to a known colonic lesion, structural abnormality, or other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is NOT covered as a colorectal cancer screening for any other indication or reason.</p> <p>The effective date for coverage of CTC for this indication is March 15, 2006.</p>	<p>CPT¹ Level III codes 0066T or 0067T.</p>
Skin Cancer:	<p>Skin Examination: Examination of the skin should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.</p>	<p>See appropriate level evaluation and management codes.</p>

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Oral Cavity and Pharyngeal Cancer:	Physical Examination: A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.	See appropriate level evaluation and management codes.
Thyroid Cancer:	Physical Examination: Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.	See appropriate level evaluation and management codes.
Infectious Diseases:	Tuberculosis (TB) Screening: Screen annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.	CPT ¹ codes 86580 and 86585.
	Rubella Antibodies: Test females once between the ages of 12 and 18, unless history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday is documented.	CPT ¹ code 86762.
	Hepatitis B Screening: Screen pregnant women for HBsAG during prenatal period.	CPT ¹ code 87340.
Cardiovascular Diseases:	Cholesterol Screening: Age-specific, periodic lipid panel as recommended by the National Heart, Lung, and Blood Institute (NHLBI). Refer to the NHLBI web site (http://www.nhlbi.nih.gov/guidelines) for current recommendations.	CPT ¹ code 80061.
	Blood Pressure Screening: For children: annually between three and six years of age, and every two years thereafter. For adults: a minimum frequency of every two years.	See appropriate level evaluation and management codes.
	Abdominal Aortic Aneurysm (AAA): One time AAA screening by ultrasonography for men, age 65-75, who have ever smoked.	CPT ¹ code 76999.
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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
<p>Other:</p>	<p>Body Measurement: For children and adolescents: Height and weight typically is measured and Body Mass Index (BMI)-for-age calculated and plotted at each primary care visit using the CDC "Data Table of BMI-for-age Charts". Children/adolescents with a BMI value greater than the 85th percentile typically receive appropriate nutritional and physical activity counseling as part of the primary care visit. Head circumference typically is measured through age 24 months. For adults: Height and weight typically is measured and BMI calculated at each primary care visit. Individuals identified with a BMI of 25 or above typically receive appropriate nutritional and physical activity counseling as part of the primary care visit.</p>	<p>See appropriate level evaluation and management codes.</p>
	<p>Vision Care: Pediatric vision screening at birth and approximately six months of age to include determination of vision on visual acuity, ocular alignment and red reflex, along with external examination of ocular abnormalities. Routine eye examination once every two years for all TRICARE Prime enrollees age three and older. Diabetic patients, at any age, should have routine eye examinations at least yearly.</p>	<p>CPT¹ codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.</p>
	<p>NOTE: Routine eye examinations are meant to be more than the standard visual acuity screening test conducted by the member's primary care physician through the use of a standard Snellen wall chart. Self-referral will be allowed for routine eye examinations since PCMs are incapable of providing this service (i.e., a Prime beneficiary will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist).</p>	
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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	<p>Hearing Screening: According to the American Academy of Pediatrics (AAP) and the Joint Committee on Infant Hearing (JCIH) all newborns should undergo hearing screening using evoked Otoacoustic Emissions (OAE) testing or automatic Auditory Brainstem Response (ABR) testing before one month of age; preferably, before leaving the hospital. An infant who does not pass the hearing screening should undergo appropriate audiological and medical evaluations to confirm the presence of a hearing loss at no later than three months of age.</p> <p>A hearing evaluation should be a part of routine examinations for all children, and those with possible hearing impairment should be referred for appropriate testing.</p>	CPT ¹ codes 92551 and 92585 - 92588.
	<p>Pediatric Blood Lead: Assessment of risk for lead exposure by structured questionnaire based on Centers for Disease Control and Prevention (CDC) Preventing Lead Poisoning in Young Children (October 1991) during each well child visit from age six months through six years. Screening by blood lead level determination for all children at high risk for lead exposure per CDC guidelines.</p>	CPT ¹ code 83655.
	<p>Patient & Parent Education Counseling: Dietary Assessment & Nutrition; Physical Activity & Exercise; Cancer Surveillance; Safe Sexual Practices; Tobacco, Alcohol and Substance Abuse; Accident & Injury Prevention; Promoting Dental Health; Stress, Bereavement, & Suicide Risk Assessment.</p>	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.
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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
<p>Other (Continued):</p>	<p>Immunizations: Age appropriate dose of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the CDC and the Secretary of Health and Human Services (HHS) and published in a CDC <i>Morbidity and Mortality Weekly Report</i> (MMWR). Refer to the CDC's home page (http://www.cdc.gov) for current schedule of CDC recommended vaccines for use in the United States.</p> <p>The effective date of coverage for immunizations recommended by the CDC is the date that the ACIP recommendations for a particular vaccine or immunization are published in CDC MMWR or October 6, 1997, whichever is later.</p> <p>Immunizations recommended specifically for travel outside the United States are NOT covered, EXCEPT for those required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service.</p>	
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