Chapter 7 Section 2.2

Clinical Preventive Services - TRICARE Prime And TRICARE Select

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1.0 POLICY

1.1 TRICARE Prime enrollees may receive Prime clinical preventive services from any network provider within their region of enrollment without referral or authorization. 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 Primary Care Manager (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 contractor payment is made under the Point of Service (POS) option only for services that are otherwise covered under the TRICARE Basic Program. Payment will not be made under the POS option for clinical preventive services that are not otherwise covered under the TRICARE Basic Program.

1.2 Beginning January 1, 2018, TRICARE Select enrollees may receive TRICARE Prime clinical preventive services when furnished by a network provider. If a TRICARE Select enrollee uses a non-network provider, payment is made only for the clinical preventive services that are otherwise covered under the TRICARE Basic Program. See Section 2.1.

1.3 There shall be no copayments 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 Current Procedural Terminology (CPT) procedure code is individually reimbursable. A 30 day administrative tolerance will be allowed for any time interval requirements imposed on services covered by this policy, e.g., if an asymptomatic woman 40 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.

1.4 The services identified in this policy are applicable to beneficiaries six years of age and older. Health Promotion and Disease Prevention (HP&DP) annual examinations for those beneficiaries age 6-21 include those services recommended by the American Academy of Pediatrics and Bright Futures guidelines. This includes developmental observation, physical examination, screening, immunizations, and anticipatory guidance. For beneficiaries under age six, covered preventive services are identified in the TRICARE well-child care policy. See Section 2.5.

1.5 Covered services as identified in this policy are based on recommendations from the United States Department of Health and Human Services (HHS). This includes recommendations from the United States Preventive Services Task Force, the Health Resources and Services Administration, etc. For the benefits under this program, the effective date of coverage is the publication date of the corresponding recommendation from the HHS.

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
HEALTH PROMOTION AND DISEASE PREVENTION (HP&DP) EXAMINATIONS	For ages six year and or older: One HP&DP examination is covered annually.	CPT codes 99383 - 99387 and 99393 - 99397.
WELL WOMAN EXAMINATIONS	HP&DP exams for the purpose of a well woman exam are covered annually for female beneficiaries under age 65. If the primary care clinician determines that a patient requires additional well woman visits to obtain all necessary recommended preventive services that are age and developmentally appropriate, these may be provided without copay and subject to reasonable medical management.	CPT codes 99383 - 99386 and 99393 - 99396.
TARGETED CLINICAL PREVENTIVE SERVICES	The following clinical preventive services may be performed during either an HP&DP exam or a well woman exam.	
Breast Cancer:	**Clinical Breast Examination (CBE)**: A CBE may be performed during a covered HP&DP exam.	See appropriate level evaluation and management codes and HCPCS code G0101.
	BRCA1 or BRCA2 Genetic Counseling and Testing: Genetic counseling rendered by a TRICARE-authorized provider that precedes BRCA1 or BRCA2 gene testing is covered for women who are identified as **high risk** for breast cancer by their primary care clinician.	CPT codes 99401 - 99404.
	BRCA1 or BRCA2 gene testing is covered for women who meet the coverage guidelines outlined in the TRICARE Operations Manual (TOM), Chapter 18, Section 3, Figure 18.3-1.	
	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 6. History of Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with a history of one of these syndromes.	CPT codes 77052 and 77057. HCPCS codes G0202.

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	Note: The risk factors identified above for screening mammography are those established by the American Cancer Society.	
	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: 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 Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with a history of one of these syndromes.	CPT codes 77058 and 77059.
	Note: The risk factors identified above for breast cancer screening MRI are those established by the American Cancer Society.	
Cervical Cancer	**Pelvic Examination**: A pelvic examination should be performed as part of a well woman exam and in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See appropriate level evaluation and management codes and HCPCS code G0101.
	Pap Smears: For dates of service prior to May 8, 2015, cancer screening Pap smears should be performed for women who are at risk for sexually transmittable diseases, women who have or have had multiple sexual partners (or if their partner has or has had multiple sexual partners), women who smoke cigarettes, and women 18 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Director, Defense Health Agency (DHA). The frequency of the screening Pap smears will be at the discretion of the patient and clinician but not less frequent then every three years.	CPT codes 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, and 88175. HCPCS codes G0123, G0124, and G0141 - G0148.
	For dates of service on or after May 8, 2015, cancer screening Pap smears are covered for female beneficiaries beginning at age 21. Women under age 21 should not be screened regardless of the age of sexual initiation or other risk factors. The frequency of screening Pap smears may be at the discretion of the patient and clinician; however, screening Pap smears should not be performed less frequently than once every three years.	
	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. 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.	CPT codes 87623 - 87625.

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Colorectal Cancer:	The following cancer screenings and frequencies are covered for individuals at **average risk** for colon cancer:	
	Fecal Occult Blood Testing (FOBT): Either guaiac-based or immunochemical-based testing of three consecutive stool samples once every 12 months for beneficiaries who have attained age 50 (i.e., at least 11 months must have passed following the month in which the last covered screening fecal-occult blood test was done).	CPT codes 82270 and 82274. HCPCS code G0328.
	Fecal Immunochemical Testing (FIT-DNA): FDA approved stool DNA tests (e.g., Cologuard™) once every three years beginning at age 50.	CPT code 81528
	Proctosigmoidoscopy or Flexible Sigmoidoscopy: Once every three to five years beginning at age 50.	CPT codes 45300 - 45305, 45308 - 45315, 45320, 45321, 45330, 45331, 45333, 45338, and 45346. HCPCS codes G0104 and G6022.
	Computed Tomographic Colongraphy (CTC): Once every five years beginning at age 50.	CPT code 74263.
	Optical (Conventional) Colonoscopy: Once every 10 years beginning at age 50. A family history of colorectal cancer or adenomatous polyps increases an individual's risk of colon cancer. The following identifies these risk factors and the cancer screenings and frequencies covered for individuals at **increased risk** for colon cancer: One or more first-degree relatives 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 every three to five years beginning at age 40 or 10 years earlier than the youngest affected relative, whichever is earlier. One or more first-degree relatives diagnosed with sporadic colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colon cancer. Either flexible sigmoidoscopy (once every five years) or optical colonoscopy (once every 10 years) should be performed beginning at age 40.	CPT codes 45355 and 45378 - 45385. HCPCS codes G0105 and G0121.
	Certain other risk factors put an individual at high risk for colon cancer. The following identifies these risk factors and the cancer screenings and frequencies covered for individuals at high risk for colon cancer: Individuals with known or suspected Familial Adenomatous Polyposis (FAP). Annual flexible sigmoidoscopy beginning at age 10 to 12. Family history of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) syndrome. Optical colonoscopy should be performed once every one to two years beginning at age 20 to 25, or 10 years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier.	

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	Individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease. For these individuals, 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. **Note:** The risk factors identified above for colorectal cancer are those established by the American Cancer Society.	
Prostate Cancer:	**Rectal Examination**: Digital rectal examination will be offered annually for all men beginning at age 50 who have at least a 10 year life expectancy. It should also be offered to begin for men age 45 and over with a family history of prostate cancer in at least one other first- degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65) and to all African American men aged 45 and over regardless of family history. Testing should be offered to start at age 40 for men with a family history of prostate cancer in two or more other family members.	See appropriate level evaluation and management codes and HCPCS code G0102.
	Prostate-Specific Antigen (PSA): Annual testing for the following categories of males may be offered: 1. Men aged 50 years and older. 2. Men aged 45 years and over with a family history of prostate cancer in at least one other family member. 3. African American men aged 45 and over regardless of family history. 4. Men aged 40 and over with a family history of prostate cancer in two or more other family members. A discussion between the beneficiary and his provider on the risks/benefits of PSA testing is encouraged.	CPT codes 84152 - 84154. HCPCS code G0103.
Testicular Cancer:	**Physical Examination**: Examination of the testis should be performed annually for males age 13-39 with a history of cryptorchidism, orchiopexy, or testicular atrophy.	See appropriate level evaluation and management codes.
Skin Cancer:	**Physical 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.	See appropriate level evaluation and management codes.
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.	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.
Lung Cancer:	**Low-Dose Computed Tomography**: Screening covered annually for persons 55 through 80 years of age with a 30 pack per year history of smoking who are currently smoking or have quit within the past 15 years. Screening should be discontinued once the individual has not smoked for 15 years or develops a health problem significantly limiting either life expectancy or ability or willingness to undergo curative lung surgery.	CPT code 71250 HCPCS code G0297.

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Immunizations:	Coverage is extended for the age appropriate dose of vaccines that meet the following requirements: 1. The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) for use in the United States; and 2. The ACIP adopted recommendations have been accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC Morbidity and Mortality Weekly Report (MMWR). 3. The effective date of coverage for CDC recommended vaccines is the date ACIP recommendations for the vaccine are published in an MMWR. Refer to the CDC's web site (http://www.cdc.gov) for a current schedule of CDC recommended vaccines for use in the United States. Immunizations recommended specifically for travel outside the United States are NOT covered, EXCEPT for immunizations 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. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.	
Infectious Diseases:	**Tuberculosis (TB) Screening**: Screen annually, regardless of age, all individuals at **high risk** for tuberculosis (as defined by the CDC using Mantoux tests).	CPT codes 86480, 86481, and 86580.
	Rubella Antibodies: Test females, once, between the ages of 12 and 18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday is documented.	CPT code 86762.
	Hepatitis B Virus (HBV) Screening: Screen for HBV in individuals at **high risk** for infection.	CPT codes 86704 - 86706, 87340, and 87341.
	Hepatitis C Virus (HCV) Screening: Screen for HCV in individuals at **high risk** for infection and as a one-time screening for adults born between 1945 and 1965.	CPT codes 86803 and 86804. HCPCS code G0472.
	Human Immunodeficiency Virus (HIV) Infection Screening: Screen for HIV in individuals ages 15-65. Younger adolescents and older adults who are at **increased risk** should also be screened.	CPT codes 86689, 86701 - 86703, 87389 - 87391, 87534 - 87536, and 87806.
	Syphilis Infection Screening: Screen at risk individuals for syphilis infection.	CPT codes 86592, 86593, and 86780.
	Chlamydia and Gonorrhea Screening: Screen sexually active women age 24 years and younger and older women who are at **increased risk** for infection.	CPT codes 86631, 86632, 87110, 87270, 87320, 87490 - 87492, 87590 - 87592, 87800, 87801, 87810, and 87850.
Diabetes Mellitus (Type II):	**Diabetes Mellitus (Type II) Screening**: Screen adults with a sustained blood pressure (treated or untreated) greater than 135/80 mmHg. Screen adults aged 40-70 who are overweight or obese.	CPT codes 82947 - 82952 and 83036.

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Cardiovascular Diseases:	**Cholesterol Screening**: Screen children once between the ages of 9 and 11 and again between the ages of 17 and 21. Screen men age 35 and older. Screen men and women age 20 and older who are at **increased risk** for coronary heart disease.	CPT codes 80061, 82465, 83718 - 83721, and 84478.
	Blood Pressure Screening: At least every two years after age six.	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 code 76700 and 76775. HCPCS code G0389.
Osteoporosis:	**Osteoporosis Screening**: Screen women for osteoporosis whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	CPT codes 76977 and 77078 - 77081. HCPCS code G0130.
Intensive Behavioral Counseling for Sexually Transmitted Infections (STIs):	**Intensive Behavioral Counseling for STIs**: Intensive behavioral counseling (counseling that lasts more than 30 minutes) for all sexually active individuals who are at **increased risk** for STIs is covered when rendered by a TRICARE authorized provider.	CPT codes 99401 - 99404. HCPCS code G0445.
Intensive, Multicomponent Behavioral Interventions for Obesity:	For adults with a Body Mass Index (BMI) of 30 kg/m2 or higher and for children/adolescents with a BMI value greater than the 95th percentile, intensive, multicomponent behavioral interventions to promote sustained weight loss (12 to 26 sessions in a year) are covered when rendered by a TRICARE authorized provider. Intensive, multicomponent behavioral interventions include, but are not limited to: behavioral management activities such as setting weight-loss goals; diet and physical activity guidance; addressing barriers to change; active self-monitoring; and, strategies to maintain lifestyle changes.	CPT codes 97802 -97804, 99401, and 99402. HCPCS codes G0270, G0271, G0447, G0473, and S9470.
Prenatal Screening Tests:	See Chapter 4, Section 18.1.	
Breast Pumps, Breast Pump Supplies, and Breastfeeding Counseling:	See Chapter 8, Section 2.6.	
Well-Child Care:	See Section 2.5.	
Other:	**School Physicals**: Physical examinations required in connection with school enrollment are covered.	CPT codes 99383 and 99393.
	Physical Examinations Required for Travel Outside the United States – Orders Required: A physical examination provided when required in the case of a family member who is traveling outside the United States as a result of the member's assignment and such travel is being performed under orders issued by a Uniformed Service is covered. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.	See appropriate level evaluation and management codes.

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	Body Measurement: For children and adolescents: Height and weight typically is measured and 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 primary care visit.	See appropriate level evaluation and management codes.
	Vision Care: Routine eye exam once every two years for retirees and eligible family members who are enrolled in Prime. Routine eye exams are not a covered benefit for retirees and eligible family members who are enrolled in TRICARE Select. Active Duty Family Members (ADFMs) who are enrolled in Prime or Select may receive a routine eye exam annually (see Section 6.1).	CPT codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	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).	
	Note: TRICARE diabetic beneficiaries may receive medically necessary eye exams IN ADDITION to the routine eye exams they receive as a preventive benefit.	
	Note: When a beneficiary's eligibility status changes from Active Duty Service Member (ADSM) or Prime ADFM to Prime retiree or retiree family member, the two-year time requirement between routine eye examinations will start on the date of the eligibility status change. That is, a Prime retiree or retiree family member will be eligible for a routine eye examination in the first year of the status change regardless of whether or not an examination was performed in the previous year under ADFM eligibility status. The eligibility status of the beneficiary will dictate the coverage parameters of the eye examination.	
	Hearing Screening: 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.	See appropriate level evaluation and management codes.
	Patient & Parent Education And Counseling: • Accident & Injury Prevention; • Cancer surveillance; • Depression, stress, bereavement, & suicide risk assessment; • Dietary assessment & nutrition; • Intimate partner violence and abuse; • Physical activity & exercise; • Promoting dental health; • Risk reduction for skin cancer; • Safe sexual practices; and • Tobacco, alcohol and substance abuse.	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

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