Chapter 7 Section 2.1

Clinical Preventive Services - TRICARE Basic Program Benefits

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1.0 CPT PROCEDURE CODES

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2.0 HCPCS PROCEDURE CODES

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3.0 POLICY

Preventive care is not directly related to specific illness, injury, a definitive set of symptoms, or obstetrical care, but rather is performed as a periodic health screening, health assessment, or periodic health maintenance.

The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009 (Public Law 110-417, Section 711) waived cost-share requirements for certain preventive services rendered on or after October 14, 2008. (See the TRICARE Reimbursement Manual (TRM), Chapter 2, Section 1 for services for which cost-shares were eliminated.)

Effective January 1, 2017, cost-shares are also eliminated for the services listed in paragraphs 3.1.1.1.2 and 3.1.5.1 through 3.1.5.12.

Effective January 1, 2018, cost-shares are eliminated for the services listed in paragraph 3.1.5.13.

See Section 2.2, for the clinical preventive services covered under TRICARE Prime and TRICARE Select.

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.

The services identified in this policy are applicable to beneficiaries age six years and older. For beneficiaries under age six, covered preventive services are identified in the TRICARE well-child care policy. (See Section 2.5.)

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.

3.1 Covered Services Exempt from Cost-Share Requirements

The following preventive services are covered and exempt from cost-share requirements:

3.1.1 Cancer Screening Examinations and Services

3.1.1.1 Breast Cancer

3.1.1.1.1 Clinical Breast Examination (CBE)

A CBE may be performed during a covered Health Promotion and Disease Prevention examination.

3.1.1.1.2 BRCA1 Or BRCA2 Genetic Counseling And Testing

3.1.1.1.2.1 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.

3.1.1.1.2.2 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.

3.1.1.1.3 Screening Mammography

3.1.1.1.3.1 Screening mammography is covered annually for all women beginning at age 40.

3.1.1.1.3.2 Screening mammography is 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:

3.1.1.1.3.2.1 History of breast cancer, Ductal Carcinoma In Situ (DCIS), Lobular Carcinoma In Situ (LCIS), Atypical Ductal Hyperplasia (ADH), or Atypical Lobular Hyperplasia (ALH);

3.1.1.1.3.2.2 Extremely dense breasts when viewed by mammogram;

3.1.1.1.3.2.3 Known BRCA1 or BRCA2 gene mutation;

3.1.1.1.3.2.4 First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves;

3.1.1.1.3.2.5 Radiation therapy to the chest between the ages of 10 and 30 years; or

3.1.1.1.3.2.6 History of Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with a history of one of these syndromes.

Note: The risk factors identified above for a screening mammography are those established by the American Cancer Society.

3.1.1.1.4 Breast Magnetic Resonance Imaging (MRI)

3.1.1.1.4.1 Breast MRI is covered annually, in addition to the annual screening mammogram, beginning at age 30 and at age 35 for services rendered prior to September 7, 2010, 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:

3.1.1.1.4.1.1 Known BRCA1 or BRCA2 gene mutation;

3.1.1.1.4.1.2 First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves;

3.1.1.1.4.1.3 Radiation therapy to the chest between the ages of 10 and 30; or

3.1.1.1.4.1.4 History of LiFraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome, or first-degree relative with a history of one of these syndromes.

Note: The risk factors identified above for a breast cancer screening MRI are those established by the American Cancer Society.

3.1.1.2 Cervical Cancer

3.1.1.2.1 Pelvic Examination

A pelvic examination should be performed as part of a well woman exam and in conjunction with Papanicolaou (Pap) smear testing for cervical neoplasms and premalignant lesions.

3.1.1.2.2 Pap Smears

3.1.1.2.2.1 For dates of service prior to May 8, 2015, cancer screening Pap smears should be performed for women who are at risk for sexually transmissible 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 Pap smears will be at the discretion of the patient and clinician but not less frequent than every three years.

3.1.1.2.2.2 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.

3.1.1.2.3 Human Papillomavirus (HPV) Deoxyribonucleic Acid (DNA) Testing

3.1.1.2.3.1 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.

3.1.1.2.3.2 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.

3.1.1.3 Colorectal Cancer

3.1.1.3.1 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 have passed following the month in which the last covered screening FOBT was done).

- Fecal Immunochemical Testing (FIT-DNA). FDA approved stool DNA tests (e.g., Cologuard™) once every three years beginning at age 50.

- Proctosigmoidoscopy or Flexible Sigmoidoscopy. Once every three to five years beginning at age 50.

- Computed Tomographic Colonography (CTC). Once every five years beginning at age 50.

- Optical (Conventional) Colonoscopy. Once every 10 years beginning at age 50.

3.1.1.3.2 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.

3.1.1.3.3 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.

- 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.

3.1.1.4 Prostate Cancer

3.1.1.4.1 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.

3.1.1.4.2 Prostate-Specific Antigen (PSA)

3.1.1.4.2.1 Annual testing may be offered for the following categories of males:

- 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.

- African American men aged 45 and over regardless of family history.

- Men aged 40 and over with a family history of prostate cancer in two or more other family members.

3.1.1.4.2.2 A discussion between the beneficiary and his provider on the risks/benefits of PSA testing is encouraged.

3.1.1.4.2.3 Screening may continue to be offered as long as the individual has a 10 year life expectancy.

3.1.1.5 Other

The cancer screenings indicated below may be performed during any covered office visit, and reimbursement is included in the allowance for the visit.

3.1.1.5.1 Testicular Cancer Screening

Examination of the testis should be performed annually for males age 13-39 with a history of cryptorchidism, orchiopexy, or testicular atrophy.

3.1.1.5.2 Skin Cancer Screening

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.

3.1.1.5.3 Oral Cavity and Pharyngeal Cancer Screening

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.

3.1.1.5.4 Thyroid Cancer Screening

Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.

3.1.2 Immunizations

3.1.2.1 Coverage is extended for the age appropriate dose of vaccines that meet the following requirements:

- The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) for use in the United States (U.S.); and

- 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).

- The effective date of coverage for CDC recommended vaccines is the date ACIP recommendations for the vaccine are published in a MMWR.

3.1.2.2 Refer to the CDC's web site (http://www.cdc.gov) for a current schedule of CDC recommended vaccines for use in the U.S.

3.1.2.3 Immunizations recommended specifically for travel outside the U.S. are NOT covered, EXCEPT for immunizations required by dependents of active duty military personnel who are traveling outside the U.S. 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.

3.1.3 Health Promotion And Disease Prevention (HP&DP) Examinations

HP&DP exams are covered when rendered in connection with one of the cancer screenings listed in paragraph 3.1.1 or a covered immunization as delineated in paragraph 3.1.2, or for well woman exams as indicated in paragraph 3.1.4.

3.1.4 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 cost-sharing and subject to reasonable medical management. There is no requirement that a well woman exam (HP&DP exam) be rendered in connection with a covered cancer screening or immunization.

3.1.5 Other Screenings And Services

The following services are covered when rendered during a covered HP&DP exam or a well woman exam, as delineated in paragraphs 3.1.3 and 3.1.4, or when ordered/recommended during one of these exams:

3.1.5.1 Tuberculosis (TB) Screening. Screen annually, regardless of age, for all individuals at high risk for TB (as defined by the CDC) using Mantoux tests.

3.1.5.2 Rubella Antibodies. Test females once, between ages 12-18, unless a history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday is documented.

3.1.5.3 Hepatitis B Virus (HBV) Screening. Screen for HBV in individuals at high risk for infection.

3.1.5.4 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.

3.1.5.5 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.

3.1.5.6 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.

3.1.5.7 Syphilis Infection Screening. Screen at risk individuals for syphilis infection.

3.1.5.8 Chlamydia and Gonorrhea Screening. Screen sexually active women age 24 years and younger and older women who are at **increased risk** for infection.

3.1.5.9 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.

3.1.5.10 Blood Pressure Screening. Blood pressure screening at least every two years after age six.

3.1.5.11 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.

3.1.5.12 Intensive Behavioral Counseling for Sexually Transmitted Infections (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.

3.1.5.13 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.

3.1.5.14 For prenatal screening tests, see Chapter 4, Section 18.1.

3.1.6 Breast Pumps, Breast Pump Supplies, and Breastfeeding Counseling

For coverage of breast pumps, breast pump supplies and breastfeeding counseling, see Chapter 8, Section 2.6.

3.1.7 Well-Child Care

For coverage of well-child care, see Section 2.5.

3.2 Covered Services Not Exempt From Cost-Sharing Requirements

Regular cost-sharing requirements apply to the following services:

3.2.1 School Physicals

Physical examinations required in connections with school enrollment are covered.

3.2.2 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.

3.2.3 Routine Eye Examinations

One routine eye exam per calendar year per person is covered for family members of Service members. Routine eye exams are excluded for retirees and their family members. See Section 6.1.

Note: Routine eye exams 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.

Note: TRICARE diabetic beneficiaries may receive medically necessary eye exams IN ADDITION to the routine eye exams they receive as a preventive benefit.

3.2.4 Audiology Screening

Preventive hearing examinations are only allowed under the well-child care benefit.

3.3 Other

The following services are covered as expected components of good clinical practice and are integrated into the appropriate office visit at no additional charge:

3.3.1 Counseling

3.3.1.1 Patient and parent education and counseling for:

- Accident and injury prevention;
- Cancer surveillance;
- Depression, stress, bereavement, and suicide risk assessment;
- Dietary assessment and nutrition;
- Intimate partner violence and abuse;
- Physical activity and exercise;
- Promoting dental health;
- Risk reduction for skin cancer;
- Safe sexual practices; and
- Tobacco, alcohol and substance abuse.

3.3.2 Body Measurements

For adults, height and weight is typically 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. 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.

4.0 EFFECTIVE DATES

4.1 The NDAA for FY 2009 (Public Law 110-417, Section 711) waived cost-share requirements for certain preventive services rendered on or after October 14, 2008. (See the TRM, Chapter 2, Section 1 for services for which cost-shares were eliminated.)

4.2 Effective January 1, 2017, cost-shares are eliminated for the services outlined in paragraphs 3.1.1.1.2 and 3.1.5.1 through 3.1.5.12.

4.3 Effective January 1, 2018, cost-shares are eliminated for the services listed in paragraph 3.1.5.13.

4.4 For the benefits under this program, the effective date of coverage is the publication date of the corresponding recommendation from the HHS.

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