CHAPTER 7
SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

ISSUE DATE: April 19, 1983
AUTHORITY: 32 CFR 199.4(e)(3)(ii) and (g)(37)

I. CPT[1] PROCEDURE CODES

45300 - 45339, 45355 - 45385, 76092, 80061, 82270, 82274, 84153, 86580, 86585, 86762, 87340, 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, 88175, 90281 - 90396, 99172, 99173, 99201 - 99215, 99381 - 99387, 99391 - 99397

II. HCPCS PROCEDURE CODES

Level II Codes G0104, G0105, G0107, G0121, G0202, G0206

III. BACKGROUND

The Defense Authorization Act for fiscal year 1996 (P.L. 104-106, Section 701) signed into effect on February 10, 1996, expands well-baby visits and immunizations to family members under the age of six and establishes immunizations and comprehensive preventive benefits for family members age six and above to include health promotion and disease preventive visits provided in connection with immunizations, pap smears, and mammograms. The Defense Authorization Act for fiscal year 1997 (P.L. 104-201, Section 701) signed into effect on September 23, 1996, further expands health care preventive services for colon and prostate cancer examinations. Periodic health examinations that include risk assessment, physical examination, laboratory tests, x-rays, and risk specific counseling will allow for the prevention, early detection and treatment of diseases before they manifest themselves as major health problems. Prior to these Acts, preventive services were quite limited. In addition to pap smears, mammograms, and well-baby care up to the age of two, the only related services authorized under Extra and Standard plans in the absence of symptoms were immunizations for family members accompanying an active duty member on overseas duty. The expanded preventive services will generally be reflective of those currently being offered to Prime enrollees under the Uniform HMO Benefit (see 32 CFR 199.18(b)(2)), except for the application of appropriate cost-sharing and deductibles under Extra and Standard plans.

While immunizations are provided as a specific exception to the general preventive care exclusion under the Regulation (32 CFR 199.4(g)(37)) and can be provided independently of other preventive services for those age six and older, the other expanded services (i.e.,

[1] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

preventive services reflective of those currently being offered to Prime enrollees under Uniform HMO Benefit) must be provided in connection with immunizations, pap smears, mammograms, and other cancer screening authorized by 10 U.S.C. 1079. For example, if a eligible female goes in for a routine pap smear, she is also eligible to receive a wide variety of other preventive services such as tuberculosis screening, rubella antibody screening, blood pressure screening, cholesterol screening test and preventive counseling services, to name a few. However, the same coverage will not be extended if she simply makes an appointment for a routine health promotion visit, where one or more of the associated preventive services (i.e., pap smear, mammogram, immunization and/or other cancer screening authorized by 10 U.S.C. 1079) are not performed.

Preventive physical examinations (for example, oral cavity examinations for pharyngeal cancer, palpation for thyroid nodules, skin cancer screening, and examinations for testicular cancer) are paid under the same comprehensive health promotion and disease prevention examination office visit code (CPT[2] procedure codes 99381-99387 and 99391-99397) as the associated pap smear, mammogram, immunization or other cancer screening examination authorized by 10 U.S.C. 1079. In other words, these additional physical examinations are being performed during the same office visit as required to perform the associated pap smear, mammogram, immunization or other cancer screening authorized by 10 U.S.C. 1079.

IV. 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 following services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health:

A. Health Promotion and Disease Prevention Examinations. The following prevention services are specific exceptions to the general preventive care exclusion under the Regulation. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the following preventive services are individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below:

1. Cancer Screening Examinations and Services.

a. Breast Cancer:

(1) Physical Examination. For women under age 40, physicians may elect to perform clinical breast examination for those who are at high risk, especially those whose first-degree relatives have had breast cancer diagnosed before menopause. For women age 40 and older, annual clinical examinations should be performed.

[2] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

(2) X-ray mammography. Mammography is recommended as a routine screening procedure (i.e., performed in the absence of any signs or symptoms of breast disease) when ordered by a physician, or upon self-referral as outlined below for:

(a) An asymptomatic woman over the age of 39, for one screening mammography every 12 months.

(b) An asymptomatic woman 35 years of age for a baseline mammogram and one screening mammogram every 12 months thereafter if the woman is considered to be at high risk of developing breast cancer. Acceptable indicators for high risk are:

1 A personal history of breast cancer;

2 A personal history of biopsy-proven benign breast disease;

3 A mother, sister, or daughter who has had breast cancer;

4 Not given birth prior to age 30; or

5 Other acceptable high risk factors as may be recommended by major authorities (e.g., the American Academy of Family Physicians, American Cancer Society, American College of Obstetricians and Gynecologists, American College of Physicians, and U.S. Preventive Services Task Force (USPSTF)).

NOTE: Screening mammography procedures should be billed using CPT[3] procedure code 76092 except when performed in connection with other preventive services, in which case a comprehensive health promotion and disease prevention examination office visit code (CPT procedure codes 99381-99387 and 99391-99397) should be used.

(c) A 30 day administrative tolerance will be allowed for internal requirements between mammograms; e.g., if an asymptomatic woman 39 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.

(d) The effective date for cancer screening mammography is November 5, 1990.

b. Cancer of Female Reproductive Organs.

(1) Physical examination. Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.

(2) Papanicolaou smears. Cancer screening Papanicolaou (PAP) tests should be performed for women who are at risk for sexually transmissible diseases, women who

[3] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

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 Executive Director, TRICARE Management Activity. The frequency of the PAP tests will be at the discretion of the patient and clinician but not less frequent then every three years.

(a) Reimbursement for screening pap smears shall not exceed the reimbursement for the intermediate office level visit except when performed in connection with other preventive services, in which case reimbursement will be allowed for the appropriate comprehensive health promotion and disease prevention examination office visit (CPT[4] procedure codes 99381-99387 and 99391-99397).

(b) Claims for screening pap smears which are coded at a level greater than the intermediate level office visit and for which no additional preventive services have been provided will be reimbursed at the allowable charge for either CPT[4] procedure code 99203 or 99213 using the EOB message: "Charge reimbursed at the intermediate office visit level." Separate charges for the preparation, handling, and collection of the screening cervical Pap test are considered to be an integral part of the routine office examination visit and will not be allowed.

(c) Reimbursement for the cytopathology laboratory procedure associated with screening Pap tests should be billed using CPT[4] procedure codes 88141-88155, 88164-88167, 88174, and 88175. Reimbursement of these procedures is limited to the total CHAMPUS Maximum Allowable Charge (CMAC) and will only be paid once regardless of whether the attending physician or the laboratory bills for the services.

(d) Reimbursement of Resource Sharing claims for the office visit associated with the screening Pap test should follow the same guidelines as civilian providers. Cytopathology laboratory charges billed by a Resource Sharing provider will not be reimbursed, unless the Resource Sharing Agreement states otherwise.

(e) Extra and Standard plans may cost-share services that are rendered during the same office visit of a screening Pap test as long as the services are considered medically necessary and are documented as such, and would not otherwise be considered integral to the office visit.

(f) A 30 day administrative tolerance will be allowed for interval requirements between screening pap tests.

(g) The effective date for cancer screening for Pap smears is November 5, 1990.

---

[4] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

c. Colorectal Cancer.

(1) Physical examination. Digital rectal examination should be performed on individuals 40 years of age and older. The effective date for coverage of a digital rectal exam is October 6, 1997.

(2) Fecal Occult Blood Testing. Once every 12 months (either guaiac-based testing or immunochemical-based testing) for beneficiaries who have attained age 50 (i.e. at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). 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.

(3) Proctosigmoidoscopy or sigmoidoscopy. Once every 3-5 years beginning at age 50. The effective date for coverage of proctosigmoidoscopy or sigmoidoscopy is October 6, 1997.

(4) Colonoscopy. Once every 10 years beginning at age 50 for individuals at average risk for colon cancer. The effective date for coverage of colonoscopy for individuals at average risk is March 15, 2006.

(a) The following age ranges and frequencies are recommended for individuals at **increased** risk for colon cancer:

1 Hereditary non-polyposis colorectal cancer syndrome. Colonoscopy should be performed every 2 years beginning at age 25, or 5 years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier. Annual screening after age 40.

2 Familial risk of sporadic colorectal cancer. Familial risk means the individual has a first degree relative with sporadic colorectal cancer or adenomas before the age of 60 or multiple first degree relatives with colorectal cancer or adenomas. Colonoscopy should be performed every 3 to 5 years beginning 10 years earlier than the youngest affected relative.

(b) The effective date for coverage of colonoscopy for individuals at **increased** risk is October 6, 1997.

(5) The effective date for colorectal cancer screening is October 6, 1997. The effective date for immunochemical-based fecal occult blood testing is August 20, 2003.

d. Prostate Cancer.

(1) Physical 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 (1) other first degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger then 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 (2) or more other family members.

(2) Prostate-Specific Antigen.

(a) Annual testing for the following categories of males:

1 All men aged 50 years and older.

2 Men aged 45 years and over with a family history of prostate cancer in at least one (1) other family member.

3 All 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 (2) or more other family members.

5 Men who have had a vasectomy at least 20 years previously or who had their vasectomy at age 40 years or older.

(b) Screening will continue to be offered as long as the individual has a 10 year life expectancy.

(3) The effective date for prostate cancer screening is October 6, 1997.

2. Infectious Diseases.

a. Hepatitis B screening. The effective date for screening pregnant women for HBsAG during the prenatal period was March 1, 1992.

b. Human immunodeficiency virus (HIV) testing.

(1) Effective July 7, 1995, TRICARE may share the cost of routine HIV screening tests for pregnant women, and

(2) Extra and Standard plans may share the cost of HIV testing when medically necessary; i.e., when performed on individuals with verified exposure to HIV or who exhibit symptoms of HIV infection (persistent generalized lymphadenopathy). Claims for HIV testing must include documentation by the attending physician verifying medical necessity. Claims that meet the criteria for coverage are to be reimbursed following the reimbursement methodology applicable to the provider's geographic location.

(3) HIV testing is covered when done in conjunction with routine pre-operative services by an independent laboratory or clinic. If the HIV testing is done while the patient is in an inpatient setting, the testing should be included in the DRG.

c. Prophylaxis. The following preventive therapy may be provided to those who are at risk for developing active disease:

(1) Tetanus immune globulin (human) and tetanus toxoid administered following an injury.

(2) Services provided following an animal bite:

(a) Extra and Standard plans may share the cost of the administration of anti-rabies serum or human rabies immune globulin and rabies vaccine.

NOTE: Pre-exposure prophylaxis for persons with a high risk of exposure to rabies is not covered.

(b) Extra and Standard plans may also cost-share the laboratory examination of the brain of an animal suspected of having rabies if performed by a laboratory which is an authorized provider and if the laboratory customarily charges for such examinations. In order for the examination charges to be paid, the animal must have bitten a beneficiary, the charges for the examination must be submitted under the beneficiary's name, and the beneficiary must be responsible for the cost-share on the claim.

NOTE: Charges by any source for boarding, observing, or destroying animals, or for the collection of brain specimens are not covered.

(3) Rh immune globulin when administered to an Rh negative woman during pregnancy and following the birth of an Rh positive child or following a spontaneous or induced abortion.

(4) For treatment provided to individuals with verified exposure to a potentially life-threatening medical condition (i.e., hepatitis A, hepatitis B, meningococcal meningitis, etc.), claims must include documentation by the attending physician verifying exposure.

(5) Isoniazid therapy for individuals at high risk for tuberculosis to include those:

(a) With a positive Mantoux test without active disease;

(b) Who have had close contact with an infectious case of TB in the past 3 months regardless of their skin test reaction; or

(c) Who are members of populations in which the prevalence of TB is greater than 10 percent regardless of their skin test reaction - including injection drug users, homeless individuals, migrant workers, and those born in Asia, Africa, or Latin America.

NOTE: In general, isoniazid prophylaxis should be continued for at least 6 months up to a maximum of 12 months.

(6) Immunizations. Coverage will be extended for the age appropriate dose of vaccines recommended and adopted by CDC's Advisory Committee on Immunization Practices (ACIP). Refer to the CDC's homepage (http://www.cdc.gov) for current schedule of recommended vaccines. 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 are covered.

3. Genetic Testing.

a. Genetic testing and counseling is covered during pregnancy under any of the following circumstances:

(1) The pregnant woman is 35 years of age or older;

(2) One of the parents of the fetus has had a previous child born with a congenital abnormality;

(3) One of the parents of the fetus has a history (personal or family) of congenital abnormality; or

(4) The pregnant woman contracted rubella during the first trimester of the pregnancy.

(5) There is a history of three or more spontaneous abortions in the current marriage or in previous mating of either spouse; or

(6) The fetus is at an increased risk for a hereditary error of metabolism detectable in vitro; or

(7) The fetus is at an increased risk for neural tube defect (family history or elevated maternal serum alpha-fetoprotein level); or

(8) There is a history of sex-linked conditions (i.e., Duchenne muscular dystrophy, hemophilia, x-linked mental retardation, etc.).

NOTE: Extra and Standard plans may not cost-share routine or demand genetic testing or genetic tests performed to establish the paternity or sex of an unborn child.

4. School Physicals.

a. Physical examinations are covered for beneficiaries ages 5 through 11 that are required in connection with school enrollment. The effective date for coverage of school enrollment physicals is October 30, 2000.

b. Cost-sharing and deductibles are to be applied as prescribed under the beneficiary's respective coverage plan (i.e., in accordance with the cost-sharing and deductible guidelines and either TRICARE Standard or Extra coverage plans).

c. Standard office visit evaluation and management CPT codes (i.e., CPT[5] procedure 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 5 through 11 (CPT[5] procedure codes 99383 & 99393).

---

[5] CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

5. Other.

a. Physical examinations and immunizations provided to the spouse and children of active duty service members in conjunction with official travel outside the United States. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.

b. Routine chest x-rays and electrocardiograms required for admission when a patient is scheduled to receive general anesthesia on an inpatient or outpatient basis.

NOTE: Extra and Standard plans may not cost-share routine chest x-rays or electrocardiograms for admissions not involving services that require general anesthesia.

B. Health Promotion and Disease Prevention Services Covered in Connection with Immunizations, Pap Smears, Mammograms, or Examinations for Colon and Prostate Cancer. The following health prevention services are only covered in connection with immunizations, pap smears, mammograms, or screening examinations for colon and prostate cancer; i.e., preventive services provided during the same comprehensive preventative office visit as the associated immunization, pap smear, mammogram, or colon and prostate examination or preventive services provided as a result of a referral made during that same office visit. The contractor shall apply all appropriate claims processing and rebundling edits before determining if the following preventive services are individually reimbursable. The contractor need not establish additional edits to identify claims within the age, sex, race, or clinical history parameters included below, or research claims history to ensure that an association exists between the following preventive services and an immunization, pap smear, mammogram, or colon and prostate cancer examination:

1. Cancer Screening Examinations.

a. Testicular Cancer. Physical examination annually for males age 13-39 with history of cryptorchidism, orchipexy, or testicular atrophy.

b. Skin Cancer. Physical skin examination should be performed for individuals with family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.

c. Oral Cavity and Pharyngeal Cancer. 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.

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

2. Infectious Diseases.

a. Tuberculosis screening. Screening annually, regardless of age, all individuals at high risk for tuberculosis (as defined by CDC) using Mantoux tests.

b. Rubella antibodies. Females, once during age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.

3. Cardiovascular Disease.

a. Cholesterol. Non-fasting total blood cholesterol at least once every five years, beginning age 18.

b. Blood pressure screening. Blood pressure screening at least every 2 years after age 6.

4. Body Measurements. Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20 percent or more above desirable weight should receive appropriate nutritional and exercise counseling.

5. Vision Screening. Vision screening continues to be excluded from coverage under the Extra and Standard plans except for the one routine eye examination per calendar year per person for family members of active duty members and vision screening allowed under the well-child benefit.

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

7. Counseling Services.

a. Patient and parent education counseling for:

(1) Dietary assessment and nutrition;

(2) Physical activity and exercise;

(3) Cancer surveillance;

(4) Safe sexual practices;

(5) Tobacco, alcohol and substance abuse;

(6) Promoting dental health;

(7) Accident and injury prevention; and

(8) Stress, bereavement and suicide risk assessment.

b. These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

V. EFFECTIVE DATE

Unless otherwise stated, the effective date of health promotion and disease prevention services covered in connection with immunizations, Pap smears, mammograms, or examinations for colon and prostate cancer is October 6, 1997.

- END -