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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 121
6010.54-M
MARCH 31, 2010**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: EVOLVING PRACTICES - JANUARY 2010

CONREQ: 14936

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See pages 3 and 4

EFFECTIVE AND IMPLEMENTATION DATE: As indicated, otherwise upon direction of the Contracting Officer.

**John A. D'Alessandro
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 41 PAGE(S)
DISTRIBUTION: 6010.54-M**

CHANGE 121
6010.54-M
MARCH 31, 2010

REMOVE PAGE(S)

CHAPTER 4

Section 6.1, pages 1 and 2
Section 15.1, page 3
Section 23.1, pages 5, 6, 9, 10

CHAPTER 5

Section 1.1, pages 3 through 7
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CHAPTER 7

Section 2.1, pages 1, 2, 5 through 12
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Section 27.1, pages 1 and 2

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Section 1.1, pages 3 through 8
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Section 27.1, pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 4

1. Section 6.1. Lumbar total disc arthroplasty for degenerative disc disease is unproven. Revised Exclusions to include the appropriate CPT codes.
2. Section 15.1. Added prostate saturation biopsy to the Exclusions list.
3. Section 23.1. Added coverage of Donor Lymphocyte Infusion (DLI) for the treatment of patients with Acute Myelogenous/Myeloid Leukemia (AML) who relapse following allogeneic stem cell transplantation.

CHAPTER 5

4. Section 1.1. Added the covered indications for Cardiovascular Magnetic Resonance (CMR); removed CPT procedure codes 0144T-0151T and added CPT codes 75571 – 75574. Revised and clarified the Exclusions paragraphs.
5. Section 4.1. Added as Exclusions: Scintimammography Breast-Specific Gamma Imaging (BSGI) and Molecular Breast Imaging (MBI) are unproven.

CHAPTER 7

6. Section 2.1. Clarified colorectal cancer risk factors and screening coverage to reflect the most current recommended guidelines of the American Cancer Society. Clarified coverage of vaccines recommended for travel outside the United States. Addressed some editorial clarifications.
7. Section 2.2. Clarified frequency or age intervals for clinical preventive services for TRICARE Prime.
8. Section 3.10. Revised the policy to exclude the use of Microcurrent Electrical Therapy (MET) and Cranial Electrotherapy Stimulation (CES) for the treatment of anxiety, depression and insomnia, and electrical stimulation devices used to apply these therapies.
9. Section 6.1. Revised policy to allow Optical Coherence Tomograph (OCT) to diagnose and monitor suspected retinal disease, rather than for glaucoma only.
10. Section 15.1. Revised the policy to exclude the use of Microcurrent Electrical Therapy (MET) and Cranial Electrotherapy Stimulation (CES) for the treatment of anxiety, depression and insomnia, and electrical stimulation devices used to apply these therapies.

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SUMMARY OF CHANGES (Continued)

CHAPTER 7 (Continued)

11. Section 18.2. Revised the policy to exclude the use of mechanical or motorized traction to provide nonsurgical spinal decompression therapy.
12. Section 27.1. Revised the policy to allow for Botulinum toxin A injections for the treatment of spasticity due to Cerebral Palsy (CP), including treatment in pediatric patients.

MUSCULOSKELETAL SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

20000 - 22505, 22520 - 22525, 22532 - 22534, 22548 - 28825, 28899 - 29863, 29866, 29867, 29870 - 29999

II. HCPCS CODES

S2360, S2361

III. DESCRIPTION

The musculoskeletal system pertains to or comprises the skeleton and the muscles.

IV. POLICY

A. 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.

B. Effective August 25, 1997, autologous chondrocyte implantation (ACI) surgery for the repair of clinically significant, symptomatic, cartilaginous defects of the femoral condyle (medial, lateral or trochlear) caused by acute or repetitive trauma is a covered procedure. The autologous cultured chondrocytes must be approved by the FDA.

C. Single or multilevel anterior cervical microdiscectomy with allogenic or autogenic iliac crest grafting and anterior plating is covered for the treatment of cervical spondylosis.

D. Percutaneous vertebroplasty (CPT¹ procedure codes 22520-22522, S2360, S2361) and balloon kyphoplasty (CPT¹ procedure codes 22523-22525) are covered for the treatment of painful osteolytic lesions and osteoporotic compression fractures refractory to conservative medical treatment.

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CHAPTER 4, SECTION 6.1

MUSCULOSKELETAL SYSTEM

E. Total Ankle Replacement (TAR) (CPT² 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.

V. EXCLUSIONS

A. Meniscal transplant (CPT² procedure code 29868) for meniscal injury is unproven.

B. Ligament replacement with absorbable copolymer carbon fiber scaffold is unproven.

C. Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents (HCPCS procedure code M0076) are unproven.

D. Trigger point injection (CPT² procedure codes 20552 and 20553) for migraine headaches.

E. IDET (Intradiscal Electrothermal Therapy) for Chronic Discogenic Pain (CPT² procedure codes 0062T and 0063T) is unproven.

F. Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace, cervical; single interspace (CPT² procedure code 22856) each additional interspace (CPT² procedure code 0092T) is unproven.

G. Removal of total disc arthroplasty anterior approach cervical; single interspace (CPT² procedure code 22864) each additional interspace (CPT² procedure code 0095T) is unproven. Also see [Chapter 4, Section 1.1](#).

H. **Lumbar total disc arthroplasty (lumbar artificial intervertebral disc replacement, lumbar total disc replacement)** for degenerative disc disease is unproven (CPT² procedure codes **22857, 22862, 0163T, 0164T, and 0165T**).

I. Extracorporeal shock wave, high energy involving the plantar fascia (CPT² procedure code 28890).

J. X STOP Interspinous Process Decompression System for the treatment of neurogenic intermittent claudication secondary to lumbar spinal stenosis is unproven.

K. Hip core decompression is unproven.

L. Femoroacetabular Impingement (FAI) open surgery, surgical dislocation (CPT² procedure codes 27140 and 27179), for the treatment of hip impingement syndrome or labral tear is unproven.

M. Hip arthroscopy (CPT² procedure code 29862) for the treatment of FAI and debridement of articular cartilage is unproven.

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IV. EXCLUSIONS

- A. Penile implants and related services when performed for psychological impotence, transsexualism, or such other conditions as gender dysphoria.
- B. Testicular prosthesis and related services when performed for transsexualism or such other conditions as gender dysphoria.
- C. Therapy for sexual dysfunctions or inadequacies (see [Chapter 7, Section 1.1.](#)).
- D. Arterial revascularization for distal lesions and venous leakage when treatment is for organic impotency.
- E. Intersex surgery, except when performed to correct sex gender confusion/ambiguous genitalia, which is documented to have been present at birth (CPT² procedure code 55970).
- F. Reversal of surgical sterilization (CPT² procedure code 55400).
- G. Cryosurgery for prostate metastases M or N is unproven.
- H. Electroejaculation (CPT² procedure code 55870).
- I. Prostate saturation biopsy (CPT² procedure code 55706).

- END -

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12. Sickle cell disease.

13. Chronic Lymphocytic Leukemia (CLL) when previous therapy has failed or when the CLL is refractory to conventional therapy.

14. Hyperesinophilic Syndrome.

15. Multiple myeloma when HCD with ABMT or PSCT has failed.

16. X-linked hyper-IgM Syndrome.

17. Chediak-Higashi Syndrome.

18. Langerhans Cell Histiocytosis, refractory to conventional treatment.

19. Hodgkin's disease.

D. Unirradiated donor lymphocyte infusion (donor buffy coat infusion, donor leukocyte infusion or donor mononuclear cell infusion) is covered for patients with CML or Acute Myelogenous/Myeloid Leukemia (AML), who relapse following their first or subsequent course of HDC with allogeneic stem cell transplantation. The medical record must document that the patient:

1. Is in relapse following an adequate trial of HDC with allogeneic stem cell transplantation of CML or AML; and

2. Qualified (or would have qualified) for authorization for HDC with allogeneic stem cell transplantation according to the provisions set forth in this policy.

E. Allogeneic UCBT, with or without HDC, is covered in the treatment of the following disease processes when either a related or unrelated donor is used. The list of indications is not all inclusive. Other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

1. Aplastic anemia.

2. Acute lymphocytic or non-lymphocytic leukemias.

3. Chronic myelogenous leukemia.

4. Severe combined immunodeficiency.

5. Wiskott-Aldrich syndrome.

6. Infantile malignant osteopetrosis.

7. Blackfan-Diamond anemia.

8. Fanconi anemia.

9. Neuroblastoma.
10. X-linked lymphoproliferative syndrome.
11. Hunter syndrome.
12. Hurler syndrome.
13. Congenital amegakaryocytic thrombocytopenia.
14. Sickle cell anemia.
15. Globoid cell leukodystrophy.
16. Adrenoleukodystrophy.
17. Kostmann's Syndrome.
18. Lesch-Nyhan disease.
19. Intermediate and high grade non-Hodgkin's lymphoma.
20. Thalassemia major.
21. Myelodysplastic Syndrome.
22. X-linked hyper-IgM Syndrome.
23. Langerhans Cell Histiocytosis, refractory to conventional treatment.

F. Syngeneic (identical twin donor) stem cell transplantation is covered for the treatment of Hodgkin's disease.

G. TRICARE will reimburse costs for donor searches.

1. Charges for donor searches must be fully itemized and billed by the transplant center.

2. Costs for donor searches will be cost-shared in accordance with established reimbursement guidelines for outpatient diagnostic testing.

3. Donor search costs may be billed at any time. There is no limit on how many searches a transplant center may request from the search printout.

H. For the purposes of TRICARE coverage, the greatest degree of incompatibility allowed between donor or recipient (for either related or unrelated donors) is a single antigen mismatch at the A, B, or Dr. locus except for:

Q. Immunoablative therapy with BMT or PSCT is unproven and not covered for the treatment of rheumatoid arthritis and juvenile idiopathic arthritis.

R. Immunoablative therapy with allogeneic BMT or allogeneic PSCT is not covered for the treatment of systemic lupus erythematosus.

V. EFFECTIVE DATES

A. May 1, 1987, for HDC with ABMT or PSCT for Hodgkin's disease, non-Hodgkin's lymphoma and neuroblastoma.

B. November 1, 1987, for HDC with ABMT or PSCT for acute lymphocytic and nonlymphocytic leukemias.

C. November 1, 1983, for HDC with allogeneic BMTs using related donors.

D. July 1, 1989, for HDC with allogeneic BMTs using unrelated donors.

E. July 11, 1996, for HDC with ABMT or PSCT for multiple myeloma.

F. January 1, 1994, for HDC with ABMT and PSCT for Wilms' tumor.

G. January 1, 1995, for allogeneic UCBTs.

H. January 1, 1994, for HDC with ABMT or PSCT for chronic myelogenous leukemia.

I. January 1, 1996, for HDC with ABMT or PSCT for Waldenstrom's macroglobulinemia.

J. January 1, 1996, for allogeneic BMTs using related three antigen mismatch donors for patients with undifferentiated leukemia, Chronic Myelogenous Leukemia (CML), aplastic anemia, Acute Lymphocytic Leukemia (ALL) or Acute Myelogenous Leukemia (AML).

K. October 1, 1996, for HDC with ABMT or PSCT for AL Amyloidosis.

L. January 1, 1995, for allogeneic BMT for hypereosinophilic syndrome.

M. May 1, 1997, for HDC with ABMT or PSCT for trilateral retinoblastoma/pineoblastoma.

N. January 1, 1997, for HDC with ABMT or PSCT for follicular lymphoma.

O. January 1, 1997, for HDC with ABMT or PSCT for non-Hodgkin's lymphoma in first complete remission.

P. November 28, 1997, for HDC with ABMT or PSCT for Hodgkin's disease in second or third remission.

Q. January 1, 1996, for HDC with allogeneic BMT for multiple myeloma.

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CHAPTER 4, SECTION 23.1
HIGH DOSE CHEMOTHERAPY AND STEM CELL TRANSPLANTATION

- R. July 1, 1999, for HDC with ABMT or PSCT for germ cell tumors in a second or subsequent relapse.
- S. January 1, 1998, for HDC with ABMT or PSCT for osteosarcoma (osteogenic sarcoma).
- T. June 1, 1995, for allogeneic BMT for Chediak-Higashi syndrome.
- U. January 1, 1998, for allogeneic PSCT.
- V. June 1, 2003, for Langerhans Cell Histiocytosis, refractory to conventional treatment.
- W. January 24, 2002, for allogeneic stem cell transplant for Hodgkin's disease.
- X. May 19, 2005, for tandem autologous PSCT for high-risk neuroblastoma.
- Y. January 1, 2006, for HDC with ABMT or PSCT for desmoplastic small round cell tumor.
- Z. April 2, 2009, for immunoablative therapy with ABMT or autologous PSCT for severe systemic lupus erythematosus, refractory to conventional treatment.

AA. November 1, 2007, for Donor Lymphocyte Infusion (DLI) for AML.

- END -

D. Cardiovascular Magnetic Resonance (CMR) (CPT³ procedure codes 75557, 75559, 75561, 75563, 75565) is covered for the following indications:

1. Detection Of Coronary Artery Disease (CAD). Symptomatic--evaluation of chest pain syndrome (use of vasodilator perfusion CMR or dobutamine stress function CMR).

- a. Intermediate pre-test probability of CAD.
- b. Electrocardiogram (ECG) uninterpretable OR unable to exercise.

2. Detection of CAD:

a. Symptomatic--evaluation of intracardiac structures (use of Magnetic Resonance (MR) coronary angiography).

b. Evaluation of suspected coronary anomalies.

3. Risk assessment with prior test results (use of vasolidator perfusion CMR or dobutamine stress function CMR).

a. Coronary angiography (catheterization or CT).

b. Stenosis of unclear significance.

4. Structure and Function. Evaluation of ventricular and valvular function. Procedures may include Left Ventricular (LV)/Right Ventricular (RV) mass and volumes, MRA, quantification of valvular disease, and delayed contrast enhancement.

a. Assessment of complex congenital heart disease including anomalies of coronary circulation, great vessels, and cardiac chambers and valves.

b. Evaluation of LV function following Myocardial Infarction (MI) OR in heart failure patients. Patients with technically limited images from echocardiogram.

c. Quantification of LV function. Discordant information that is clinically significant from prior tests.

d. Evaluation of specific cardiomyopathies (infiltrative [amyloid, sarcoid], Hypertrophic Cardiomyopathy (HCM), or due to cardiotoxic therapies.

e. Characterization of native and prosthetic cardiac valves--including planimetry of stenotic disease and quantification of regurgitant disease. Patients with technically limited images from echocardiogram or Transesophageal Echocardiography (TEE).

f. Evaluation for Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC). Patients presenting with syncope or ventricular arrhythmia.

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- g. Evaluation of myocarditis or MI with normal coronary arteries. Positive cardiac enzymes without obstructive atherosclerosis on angiography.
5. Structure and Function. Evaluation of intracardiac and extracardiac structures.
- a. Evaluation of cardiac mass (suspected tumor or thrombus). Use of contrast for perfusion and enhancement.
 - b. Evaluation of pericardial conditions (pericardial mass, constrictive pericarditis).
 - c. Evaluation for aortic dissection.
 - d. Evaluation of pulmonary veins prior to radiofrequency ablation for atrial fibrillation. Left atrial and pulmonary venous anatomy including dimensions of veins for mapping purposes.
6. Detection of Myocardial Scar and Viability. Evaluation of myocardial scar (use of late gadolinium enhancement).
- a. To determine the location and extent of myocardial necrosis including “no reflow” regions. Post acute MI.
 - b. To determine viability prior to revascularization. Establish likelihood of recovery of function with revascularization (Percutaneous Coronary Intervention [PCI] or Coronary Artery Bypass Graft [CABG]) or medical therapy.
 - c. To determine viability prior to revascularization. Viability assessment by Single Photon Emission Tomography (SPECT) or dobutamine echo has provided “equivocal or indeterminate” results.
- E. MRA is covered when medically necessary, appropriate and the standard of care. (CPT⁴ procedure codes 70544-70549, 71555, 72159, 72198, 73225, 73725, and 74185.)
- F. CT scans are covered when medically necessary, appropriate and the standard of care and all criteria stipulated in 32 CFR 199.4(e) are met. (CPT⁴ procedure codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74175, 75635, and 76355-76380.)
- G. TRICARE considers three-dimensional (3D) rendering (CPT⁴ procedure codes 76376 and 76377) medically necessary under certain circumstances (see Chapter 5, Section 2.1).
- H. Helical (spiral) CT scans, with or without contrast enhancement, are covered when medically necessary, appropriate and the standard of care.
- I. Chest x-rays (CPT⁴ procedure codes 71010-71035) are covered.

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J. Diagnostic mammography (CPT⁵ procedure codes 76090-76092/HCPCS codes G0204-G0207) to further define breast abnormalities or other problems is covered.

K. Portable X-ray services are covered. The suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations, or the Medicaid program in that state in which the covered service is provided. In addition to the specific radiology services, reasonable transportation and set-up charges are covered and separately reimbursable.

L. Bone density studies (CPT⁵ procedure codes 76070-76078) are covered for the following:

1. The diagnosis and monitoring of osteoporosis.
2. The diagnosis and monitoring of osteopenia.

3. Patients must present with signs and symptoms of bone disease or be considered at high-risk for developing osteoporosis. High-risk factors which have been identified as the standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

a. Women who are estrogen-deficient and at clinical risk for osteoporosis. Naturally or surgically post-menopausal women who have not been on **long-term** Hormone Replacement Therapy (HRT). However, **current** use of HRT does not preclude estrogen deficiency.

- b. Individuals who have vertebral abnormalities.
- c. Individuals receiving long-term glucocorticoid (steroid) therapy.
- d. Individuals with primary hyperparathyroidism.
- e. Individuals with positive family history of osteoporosis.
- f. Any other high-risk factor identified by ACOG as the standard of care.

M. Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT⁵ procedure code 72291) or under CT guidance (CPT⁵ procedure code 72292) is covered.

N. Multislice or multidetector row CT angiography (CT, heart) (CPT⁵ codes 75571 - 75574) is covered for the following indications:

1. Evaluation of heart failure of unknown origin when invasive coronary angiography +/- Percutaneous Coronary Intervention (PCI) is not planned, unable to be preformed or is equivocal.

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CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

2. In an Emergency Department (ED) for patients with acute chest pain, but no other evidence of cardiac disease (low-pretest probability), when results would be used to determine the need for further testing or observation.

3. Acute chest pain or unstable angina when invasive coronary angiography or a PCI cannot be performed or is equivocal.

4. Chronic stable angina and chest pain of uncertain etiology or other cardiac findings prompting evaluation for CAD (for example: new or unexplained heart failure or new bundle branch block).

a. When invasive coronary angiography or PCI is not planned, unable to be performed, or is equivocal; AND

b. Exercise stress test is unable to be performed or is equivocal; AND

c. At least one of the following non-invasive tests were attempted and results could not be interpreted or where equivocal or none of the following tests could be performed:

(1) Exercise stress echocardiography.

(2) Exercise stress echo with dobutamine.

(3) Exercise myocardial perfusion (SPECT).

(4) Pharmacologic myocardial perfusion (SPECT).

5. Evaluation of anomalous native coronary arteries in symptomatic patients when conventional angiography is unsuccessful or equivocal and when results would impact treatment.

6. Evaluation of complex congenital anomaly of coronary circulation or of the great vessels.

7. Presurgical evaluation prior to biventricular pacemaker placement.

8. Presurgical evaluation of coronary anatomy prior to non-coronary surgery (valve placement or repair; repair of aortic aneurysm or dissection).

9. Presurgical cardiovascular evaluation for patients with equivocal stress study prior to kidney or liver transplantation.

10. Presurgical evaluation prior to electrophysiologic procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

V. EXCLUSIONS

A. Bone density studies for the routine screening of osteoporosis.

B. Ultrafast CT (electron beam CT (HCPCS code S8092)) to predict asymptomatic heart disease is preventive. **Ultrafast CT (electron beam CT) is excluded for symptomatic patients and for screening asymptomatic patients for CAD.**

C. MRIs (CPT⁶ procedure codes 77058 and 77059) to screen for breast cancer in asymptomatic women considered to be at low or average risk of developing breast cancer; for diagnosis of suspicious lesions to avoid biopsy, to evaluate response to neoadjuvant chemotherapy, to differentiate cysts from solid lesions.

D. MRIs (CPT⁶ procedure codes 77058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.

E. 3D rendering (CPT⁶ procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.

F. 3D rendering (CPT⁶ procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.

G. 3D rendering (CPT⁶ procedure codes 76376 and 76377) for use as a screening test for CAD in healthy individuals or in asymptomatic patients who have one or more traditional risk factors for CAD is unproven.

H. CT angiography (CPT⁶ procedure codes 76376 and 76377) for acute ischemic stroke is unproven.

I. CT angiography (CPT⁶ procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.

J. CT, heart, without contrast **material, with** quantitative evaluation of coronary calcium (CPT⁶ procedure code 75571) is excluded for patients **with typical anginal chest pain with high suspicion of CAD; patients with acute MI;** and for screening asymptomatic patients for CAD.

K. CT, heart, with contrast material, **for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)** (CPT⁶ procedure code 75572) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

L. **CT, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)** (CPT⁶ procedure code 75573) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

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M. Computed tomographic angiography heart, coronary arteries and bypass (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) (CPT⁷ procedure code 75574) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute MI; and for screening asymptomatic patients for CAD.

N. Multislice or multidetector row CT angiography of less than 16 slices per sec and 1mm or less resolution is excluded.

O. Dual Energy X-Ray Absorptiometry (DXA) composition study (CPT⁷ procedure code 0028T) is unproven.

VI. EFFECTIVE DATES

A. The effective date for MRIs with contrast media is dependent on the U.S. Food and Drug Administration (FDA) approval of the contrast media and a determination by the contractor of whether the labeled or unlabeled use of the contrast media is medically necessary and a proven indication.

B. March 31, 2006, for breast MRI.

C. March 31, 2006, for coverage of multislice or multidetector row CT angiography.

D. January 1, 2007, for CPT⁷ procedure codes 72291 and 72292.

E. January 1, 2007, for coverage of multislice or multidetector row CT angiography performed for presurgical evaluation prior to electrophysiological procedure to isolate pulmonary veins for radiofrequency ablation of arrhythmia focus.

F. October 1, 2008, for breast MRI for guidance of interventional procedures such as vacuum assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI.

G. October 3, 2006, for CMR.

- END -

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standard of care by the American College of Obstetricians and Gynecologists (ACOG) include:

a. Women who are estrogen-deficient and at a clinical risk of or osteoporosis. Naturally or surgically post-menopausal women who have not been on **long-term** Hormone Replacement Therapy (HRT). However, **current** use of HRT does not preclude estrogen deficiency.

b. Individuals who have vertebral abnormalities.

c. Individuals receiving long-term glucocorticoid (steroid) therapy.

d. Individuals with primary hyperparathyroidism.

e. Individuals with positive family history of osteoporosis.

f. Any other high-risk factor identified by ACOG as the standard of care.

IV. EXCLUSIONS

A. Bone density studies for the routine screening of osteoporosis.

B. PET for the diagnosis and monitoring of treatment of Alzheimer's disease, fronto-temporal dementia or other forms of dementia is unproven.

C. PET and PET/CT for the initial diagnosis of differentiated thyroid cancer and for medullary cell thyroid cancer.

D. Ultrasound ablation (destruction of uterin fibroids) with Magnetic Resonance Imaging (MRI) guidance (CPT³ procedure code 0071T) in the treatment of uterine leiomyomata is unproven.

E. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of gastric cancer is unproven.

F. Scintimammography (HCPCS code S8080), Breast-Specific Gamma Imaging (BSGI) (CPT³ procedure codes 78800, 78801), and Molecular Breast Imaging (MBI) are unproven for all indications.

V. EFFECTIVE DATES

A. January 1, 1995, for PET for ischemic heart disease.

B. December 1, 1996, for PET for lung cancer.

C. October 14, 1990, for SPECT for myocardial perfusion imaging.

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CHAPTER 5, SECTION 4.1

NUCLEAR MEDICINE

- D. January 1, 1991, for SPECT for brain imaging.
- E. October 28, 1996, for ¹¹¹In-Capromab Pendetide, CyT 356 (ProstaScint™).
- F. June 1, 1994, for Octreoscan Scintigraphy.
- G. May 26, 1994, for bone density studies.
- H. January 1, 2007, for PET and PET/CT for lymphoma.
- I. January 1, 2006, for PET and PET/CT for pancreatic cancer.
- J. February 16, 2006, for PET and PET/CT for thyroid cancer.

- END -

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

ISSUE DATE: April 19, 1983

AUTHORITY: [32 CFR 199.4\(e\)\(3\)\(ii\)](#) and [\(g\)\(37\)](#)

I. CPT¹ PROCEDURE CODES

45300 - 45339, 45355 - 45385, 77052, 77057 - 77059, 80061, 82270, 82274, 84153, 86580, 86762, 87340, 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, 88175, 90281 - 90396, 99172, 99173, 99201 - 99215, 99381 - 99387, 99391 - 99397

II. HCPCS AND TEMPORARY PROCEDURE CODES

A. Level II Codes G0008 - G0010, **G0101** - G0105, G0121, G0202

B. Level III Codes 0066T, 0067T - Specific criteria must be met for coverage of these codes. See [paragraph IV.A.1.c\(5\)](#) for coverage criteria.

III. BACKGROUND

A. The National Defense Authorization Act for Fiscal Year (NDAA FY) 1996 (**Public Law 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, Papanicolaou (Pap) smears, and mammograms. The NDAA FY 1997 (**Public Law 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 Health Maintenance Organization (HMO) Benefit (see [32 CFR 199.18\(b\)\(2\)](#)). **The NDAA FY 2009 (Public Law 110-417, Section 711) signed into effect October 14, 2008, waives copayment requirements for certain TRICARE beneficiaries for those preventive services as described in the TRICARE**

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Reimbursement (TRM), [Chapter 2, Section 1, paragraph I.C.3.j.](#) and [paragraph I.D.3.](#) Appropriate cost-sharing and deductibles will apply for all other preventive services under Extra and Standard plans.

B. 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., 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 (TB) 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.

C. 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 (CPT² 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.

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been provided will be reimbursed at the allowable charge for either CPT⁵ 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 CPT⁵ 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.

c. Colorectal Cancer.

(1) The following cancer screenings and frequencies are covered for individuals at average risk for colon cancer:

(a) Fecal Occult Blood Testing. 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 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.

(b) Proctosigmoidoscopy or Flexible Sigmoidoscopy. Once every three to five years beginning at age 50. The effective date for coverage of proctosigmoidoscopy or sigmoidoscopy for individuals at average risk is October 6, 1997.

(c) Optical (Conventional) Colonoscopy. Once every 10 years beginning at age 50. The effective date for coverage of optical colonoscopy for individuals at average risk is March 15, 2006.

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(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:

(a) 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 five years beginning at age 40 or 10 years earlier than the youngest affected relative, whichever is earlier.

(b) 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) 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:

(a) Individuals with known or suspected Familial Adenomatous Polyposis (FAP). Annual flexible sigmoidoscopy beginning at age 10 to 12.

(b) 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.

(c) 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.

(4) The effective date for coverage of flexible sigmoidoscopy or optical colonoscopy for individuals at **increased or high risk for colon cancer** is October 6, 1997.

(5) Computed Tomographic Colonography (CTC).

(a) CTC (Level III procedure code 0066T or 0067T) 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.

(b) The effective date for coverage of CTC as indicated above is March 15, 2006.

(c) CTC is **NOT** covered as a colorectal cancer screening for any other indication or reason.

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 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.

(2) Prostate-Specific Antigen (PSA).

(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 or more other family members.

(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 Diagnostic Related Group (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.

(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 TB 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 three months regardless of their skin test reaction; or

(c) Who are members of populations in which the prevalence of TB is greater than 10% 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 six months up to a maximum of 12 months.

(6) Immunizations.

(a) 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 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**.

4 The effective date of coverage for **CDC recommended** vaccines is **October 6, 1997, OR the date ACIP recommendation** for the vaccine **were published in a MMWR, whichever date is LATER**.

(b) **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.

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

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(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 five 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., CPT⁶ 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 five through 11 (CPT⁶ procedure codes 99383 and 99393).

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

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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 **between the ages of 13 through 39** with history of cryptorchidism, orchiopexy, 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. **TB Screening**. Screen annually, regardless of age, **for** all individuals at high risk for **TB** (as defined by CDC) using Mantoux tests.

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

3. Cardiovascular Disease.

a. Cholesterol. A lipid panel at least once every five years, beginning **at** age 18.

b. Blood **P**ressure **S**creening. Blood pressure screening at least every two years after age six.

4. Body Measurements. Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20% 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 -

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

ISSUE DATE: May 15, 1996
 AUTHORITY: [32 CFR 199.17](#)

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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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:	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.	See appropriate level evaluation and management codes.
	Mammography: Annual screening mammograms for women over age 39; For high risk women (family history of breast cancer in a first degree relative), baseline mammogram age 35, then annually.	CPT ¹ codes 77052 and 77057 HCPCS codes G0202, G0204, and G0206.
	Magnetic Resonance Imaging (MRI): Annual screening breast MRI for asymptomatic women age 30 or older considered to be at high risk of developing breast cancer per the guidelines of the American Cancer Society (ACS) as follows: 1) Women with a BRCA1 or BRCA2 gene mutation; 2) Women with a first degree relative (parent, child, sibling) with a BRCA1 or BRCA2 mutation, even if untested; 3) Lifetime risk approximately 20-25% or greater as defined by BRCAPRO or other models that are largely dependent on family history; 4) History of chest radiation between the ages of 10 and 30;	CPT ¹ codes 77058 and 77059.
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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Breast Cancer (Continued):	Magnetic Resonance Imaging (MRI) (Continued): 5) History of LiFraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndromes or first degree relative with the syndrome. The effective date for breast cancer screening MRI is March 1, 2007.	
Cancer of Female Reproductive Organs:	Physical Examination: Pelvic examination should be performed in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See appropriate level evaluation and management codes.
	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.	CPT ¹ codes 88141-88155, 88164-88167, 88174, 88175, 99201-99215, or 99301-99313.
Testicular Cancer:	Physical 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:	Physical 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-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.
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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
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.
	<p>Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at Average Risk for Colon Cancer: Once every three to five years beginning at age 50.</p> <p>Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at Increased or High Risk for Colon Cancer:</p> <p>Increased Risk (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>High Risk: 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 proctosigmoidocopy or flexible sigmoidoscopy, regardless of risk, is October 6, 1997.</p>	CPT ¹ codes 45300-45321, 45327, and 45330-45339. HCPCS code G0104.
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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	<p>Optical (Conventional) Colonoscopy for Individuals at <u>Average Risk</u> for Colon Cancer: 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>Optical (Conventional) Colonoscopy for Individuals at <u>Increased or High Risk</u> for Colon Cancer:</p> <p><u>Increased Risk</u> (Individuals with a family history):</p> <ol style="list-style-type: none"> Once every five years for individuals with a first degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, 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 colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second degree relatives. <p><u>High Risk</u>:</p> <ol style="list-style-type: none"> 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. 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>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>

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	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. The effective date for coverage of CTC for this indication is March 15, 2006.	CPT ¹ Level III codes 0066T or 0067T.
Skin Cancer:	Physical Examination: Skin examination 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. 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: A lipid panel at least once every five years, beginning at age 18.	CPT ¹ code 80061.

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CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Cardiovascular Diseases (Continued):	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.
Other:	Body Measurement: For children: Height and weight should be measured regularly throughout infancy and childhood. Head circumference should be measured through age 24 months. For adults: Height and weight should be measured periodically. The optimal frequency is a matter of clinical discretion. Those individuals who are 20% or more above desirable weight should receive appropriate nutritional and exercise counseling.	See appropriate level evaluation and management codes.
	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.	CPT ¹ 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).	
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CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	<p>Hearing Screening: All neonates should undergo audiology screening before leaving the hospital. However, if not tested at birth all infants should undergo audiology screening before one month of age. Those who do not pass the audiologic screening should be tested before three months of age using Evoked Otoacoustic Emission (EOE) and/or Auditory Brainstem Response (ABR) testing.</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, 92587, and 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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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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CHAPTER 7, SECTION 3.10

TREATMENT OF MENTAL DISORDERS

C. Specific developmental disorders.

D. Home visits for individual, family, or marriage counseling (CPT³ procedure code 99510).

E. Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy.

V. EFFECTIVE DATE November 13, 1984.

- END -

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OPHTHALMOLOGICAL SERVICES

ISSUE DATE: November 3, 1992

AUTHORITY: 32 CFR 199.4(c)(2)(xvi), (e)(6), (g)(46) and (g)(50)

I. CPT¹ PROCEDURE CODE RANGES

92002 - 92060, 92070 - 92335, 92390 - 92499

II. DESCRIPTION

Ophthalmological services may include an examination and other specialized services. The purpose of an examination is to diagnose or treat a medical condition of the eye, eyelid, lacrimal system, or orbit. A "routine eye examination" is an evaluation of the eyes, including but not limited to refractive services, that is not related to a medical or surgical condition or to the medical or surgical treatment of a covered illness or injury.

III. POLICY

A. For all beneficiaries, ophthalmological services (including refractive services) provided in connection with the medical or surgical treatment of a covered illness or injury are covered.

B. Section 632 of P.L. 98-525 signed into effect on October 19, 1994, authorizes payment under TRICARE for one routine eye examination per year for dependents of active duty members.

1. Routine eye examinations as defined in 32 CFR 199.2 includes coverage of those services rendered in order to determine the refractive state of the eyes. The CPT² procedure codes for payment of routine eye examinations are as follows:

92002 - EYE EXAM, NEW PATIENT
92004 - EYE EXAM, NEW PATIENT
92012 - EYE EXAM, ESTABLISHED PATIENT
92014 - EYE EXAM & TREATMENT
92015 - REFRACTION
99172 - OCULAR FUNCTION SCREEN
99173 - VISUAL ACUITY SCREEN

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CHAPTER 7, SECTION 6.1

OPHTHALMOLOGICAL SERVICES

2. TRICARE Prime and Standard Active Duty Family Members (ADFM) are entitled to one annual routine eye examination. Prime ADFMs may receive their annual routine eye exam from any network provider without referral, authorization, or preauthorization from the Primary Care Manager (PCM), or any other authority; i.e., a Prime ADFM will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist. Standard ADFMs may self-refer to any TRICARE authorized provider regardless of whether or not they are a network provider; i.e., a Standard ADFM may set up his or her own appointment with either a network or non-network TRICARE authorized optometrist or ophthalmologist.

C. For Prime enrollees, see [Chapter 7, Section 2.2](#) for additional information on routine eye examinations.

D. Heidelberg Retina Tomograph (HRT), and Scanning laser polarimetry (GDx) (CPT² procedure code 92135) to diagnose and monitor progression of suspected glaucoma may be considered for cost-sharing. **Optical Coherence Tomograph (OCT) to diagnose and monitor progression of suspected retinal disease may be considered for cost-sharing.** Effective October 28, 2008.

IV. EXCLUSIONS

A. Routine eye examinations are NOT covered for Standard retirees or their dependents that are not enrolled in Prime except for eye exams allowed under the well-child benefit in [Chapter 7, Section 2.5](#).

B. Orthoptics, also known as vision training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT² procedure code 92065).

C. Canaloplasty in the treatment of glaucoma is unproven.

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NEUROLOGY AND NEUROMUSCULAR SERVICES

ISSUE DATE: April 19, 1983

AUTHORITY: 32 CFR 199.4(b)(2)(vii) and (b)(3)(v)

I. CPT¹ PROCEDURE CODE RANGE

95812 - 95999

II. DESCRIPTION

The diagnosis and treatment of muscle and nerve disorders.

III. POLICY

Neurology and neuromuscular services are covered.

IV. EXCLUSIONS

A. Topographic brain mapping (brain electrical activity mapping, quantitative Electroencephalogram (EEG), digital EEG, topographic EEG, brain mapping EEG) is unproven.

B. Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy, are unproven.

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13. Nonsurgical spinal decompression therapy (including Internal or Intervertebral Disc Decompression (IDD), Decompression Reduction Stabilization (DRS), or Vertebral Axial Decompression (VAX-D) therapy) provided by mechanical or motorized traction for the treatment of low back and/or neck pain is unproven. The use of powered traction devices (including, but not limited to, the Accu-SPINA™, VAX-D, and DRX9000) are likewise unproven.

14. For beneficiaries under the age of three, services and items provided in accordance with the beneficiary's Individualized Family Service Plan (IFSP) as required by Part C of the Individuals with Disabilities Education Act (IDEA), and which are otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option (ECHO) but determined not to be medically or psychologically necessary, are excluded.

15. For beneficiaries aged three to 21, who are receiving special education services from a public education agency, cost-sharing of outpatient physical therapy services that are required by the IDEA and which are indicated in the beneficiary's Individualized Education Program (IEP), may not be cost-shared except when the intensity or timeliness of physical therapy services as proposed by the educational agency are not sufficient to meet the medical needs of the beneficiary.

16. Low Level Laser Therapy (LLLT) (also known as low level light therapy or cold laser therapy) for treatment of soft tissue injuries, pain, or inflammation is unproven.

17. Spinalator therapy and use of a Spinalator Table for the treatment of neck and low back pain. Spinalator therapy is defined as a type of traction that uses the patient's weight to create the traction force in the absence of any external pulling force. The Spinalator Table is defined as a table with rollers that applies consistent pressure and movement under the patient in the absence of any external pulling devices.

- END -

BOTULINUM TOXIN A INJECTIONS

ISSUE DATE: October 12, 1998

AUTHORITY: 32 CFR 199.4(c)(2)(iii) and (c)(2)(iv)

I. CPT¹ PROCEDURE CODES

46505, 64612 - ~~64614~~, 64640, 67345

II. DESCRIPTION

These procedures involve the injection of small amounts of botulinum toxin type A into selected muscles for the nonsurgical treatment of the conditions relating to spasticity, various dystonias, nerve disorders, and muscular tonicity deviations.

III. POLICY

A. Botulinum toxin A injections may be considered for cost-sharing for treating conditions such as cervical dystonia (repetitive contraction of the neck muscles) in decreasing the severity of abnormal head position and neck pain for patients 16 years and older.

B. Botulinum toxin A injections may be considered for cost-sharing for treating conditions such as blepharospasm (spasm of the eyelids/uncontrolled blinking) and strabismus (squinting/eyes do not point in the same direction) associated with dystonia, including benign essential blepharospasm or VII nerve disorders for patients 12 years of age and older.

C. Botulinum toxin A injections may be considered for cost-sharing for treating conditions such as severe primary axillary hyperhidrosis (severe underarm sweating) that is inadequately managed by topical agents for patients 18 years of age and older.

D. Botox® (chemodenervation-CPT¹ procedure code 46505) may be considered for off-label cost-sharing for the treatment of chronic anal fissure unresponsive to conservative therapeutic measures, effective May 1, 2007.

E. Botulinum toxin A injections may be considered for off-label cost-sharing for the treatment of spasticity resulting from Cerebral Palsy (CP), effective November 1, 2008.

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IV. EXCLUSIONS

A. Botulinum toxin A injections are unproven for the following indications:

1. Palmar hyperhidrosis.
2. Urinary urge incontinence.
3. Lower back pain/lumbago.
4. Migraine headaches and other primary headache disorders.

B. Botox® (chemodenervation-CPT² procedure code 64612) for the treatment of muscle spasms secondary to cervical degenerative disc disease and spinal column stenosis is unproven.

V. EFFECTIVE DATE

May 1, 2007, for coverage of chronic anal fissure unresponsive to conservative therapeutic measures (CPT² procedure code 46505).

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