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The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.54-M, issued August 2002.

CHANGE TITLE: EVOLVING PRACTICE CHANGE SEPTEMBER 2007

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): Chapter 4, Section 5.3 - Allowing for prophylactic hysterectomies. Chapter 4, Section 17.1 - On the female genital system adds a cross-reference to Chapter 4, Section 5.3 regarding prophylactic mastectomy, oophorectomy, and hysterectomy. Chapter 5, Section 2.1 - Adds a clarification of the exclusions for 3D and 4D maternity ultrasounds.

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Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

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PROPHYLACTIC MASTECTOMY, PROPHYLACTIC OOPHORECTOMY, AND PROPHYLACTIC HYSTERECTOMY

ISSUE DATE: October 25, 1993

AUTHORITY: 32 CFR 199.4(c)(2)

I. CPT¹ PROCEDURE CODES

19300 - 19307, 58150 - 58294, 58541 - 58554, 58661, 58940 - 58956

II. DESCRIPTION

A. Prophylactic mastectomy is an extirpative procedure (usually simple or total mastectomy) which removes all breast tissue which would be otherwise subject to breast carcinoma. Carefully selected indications have been developed for prophylactic mastectomy and are included in this policy.

B. Prophylactic oophorectomy is removal of the ovaries before development of cancerous cells. Carefully selected indications have been developed for prophylactic oophorectomy and are included in this policy.

C. Prophylactic hysterectomy is removal of the uterus before development of cancerous cells. Carefully selected indications have been developed for prophylactic hysterectomy and are included in this policy.

III. POLICY

A. Bilateral prophylactic mastectomies are covered for patients at increased risk of developing breast carcinoma who have one or more of the following:

1. Atypical hyperplasia of lobular or ductal origin confirmed on biopsy; or
2. A negative or positive **Breast Cancer (BRCA)** genetic test and family history of breast cancer in a first-degree relative (especially a mother or sister) who is premenopausal and has bilateral breast cancer (Family Cancer Syndrome); or
3. Fibronodular, dense breasts which are mammographically and/or clinically difficult to evaluate and the patient presents with either of the above (or both) clinical presentations.

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B. Unilateral prophylactic mastectomies are covered when the contralateral breast has been diagnosed with cancer for patients with:

1. Diffuse microcalcifications in the remaining breast, especially when ductal in-situ carcinoma has been diagnosed in the contralateral breast; or
2. Lobular carcinoma in-situ; or
3. Large breast and/or ptotic, dense or disproportionately-sized breast that are difficult to evaluate mammographically and clinically; or
4. In whom observational surveillance is elected for lobular carcinoma in-situ and the patient develops either invasive lobular or ductal carcinoma; or
5. A negative or positive BRCA genetic test and family history of breast cancer in a first-degree relative (especially a mother or sister) who is premenopausal and has bilateral breast cancer (Family Cancer Syndrome).

C. Prophylactic oophorectomy is covered when there is a positive BRCA genetic test and:

1. There is a first degree family history of ovarian cancer (e.g., parent, child, sibling); or
2. There is a 2+2nd degree relative history of ovarian cancer (two or more second degree relatives).

D. **Prophylactic hysterectomy is covered:**

1. **For women with a positive BRCA genetic test who are about to undergo or are undergoing tamoxifen therapy.**
2. **For women who have been diagnosed with Hereditary Nonpolyposis Colorectal Cancer (HNPCC) or are found to be carriers of HNPCC-associated mutations.**

E. Benefits will only be allowed for subcutaneous mastectomies performed as an alternative treatment for benign breast diseases if the individual is not at high risk of breast cancer.

IV. EXCLUSION

Subcutaneous mastectomy, a procedure that is not extirpative, fails to remove all breast tissue. Therefore, subcutaneous mastectomy is not effective as prophylactic assurance against breast cancer in high risk indications, nor is subcutaneous mastectomy a cancer treatment. Therefore, benefits will not be allowed for subcutaneous mastectomy in the prevention of breast carcinoma. (From October 25, 1993, through the implementation date of this policy, subcutaneous mastectomy was listed as a covered benefit.) Claims processed during this time should not be recouped.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 5.3

PROPHYLACTIC MASTECTOMY, PROPHYLACTIC OOPHORECTOMY, AND PROPHYLACTIC HYSTERECTOMY

V. EFFECTIVE DATE

January 1, 2006, for prophylactic hysterectomy.

- END -

FEMALE GENITAL SYSTEM

ISSUE DATE: August 26, 1985

AUTHORITY: 32 CFR 199.4(c)(2), (c)(3), (e)(3), and (g)(34)

I. CPT¹ PROCEDURE CODES

11975 - 11977, 55980, 56405 - 58301, 58340, 58345, 58346, 58350, 58353, 58356, 58400 - 58671, 58679, 58700 - 58740, 58800 - 58960, 58999, 59001

II. DESCRIPTION

The female genital system includes the female organs of reproduction.

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the female genital system are covered. Infertility testing and treatment, including correction of the physical cause of infertility, are covered under this provision. This does not include artificial insemination, which is excluded from coverage.

B. Uterine suspension; parametrial fixation as treatment for uterine prolapse may be cost-shared only to retain the uterus for biologic purposes.

C. Intersex surgery (CPT¹ procedure code 55980) is limited to surgery performed to correct sex gender confusion/ambiguous genitalia which is documented to have been present at birth.

NOTE: For policy on prophylactic mastectomy, prophylactic oophorectomy, and prophylactic hysterectomy, see Chapter 4, Section 5.3.

IV. POLICY CONSIDERATION

Benefits are payable for Uterine Artery Embolization (UAE), as an alternative treatment to hysterectomy or myomectomy, for those individuals with confirmed, symptomatic uterine fibroids who are premenopausal and who do not wish to preserve their childbearing potential.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 17.1

FEMALE GENITAL SYSTEM

V. EXCLUSIONS

- A. Prophylactics (condoms).
- B. Over-the-counter spermicidal products.
- C. Reversal of a surgical sterilization procedure (CPT² procedure codes 58672, 58673, 58750-58770).
- D. Artificial insemination, including any costs related to donors and semen banks (CPT² procedure codes 58321-58323).
- E. In-Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and all other non-coital reproductive procedures, including all services and supplies related to, or provided in conjunction with, those technologies (CPT² procedure codes 58970-58976).
- F. Hysterectomy (CPT² procedure codes 58150-58285, 58550, 59525) performed solely for purposes of sterilization in the absence of pathology.
- G. Subtotal hysterectomy performed exclusively to preserve sexual function and/or to prevent postoperative complications (e.g., urinary incontinence; vaginal prolapse).
- H. Cervicography (CPT² category III procedure code 0003T) is unproven.
- I. Uterine Artery Embolization (UAE) for individuals with specific contraindications, including such conditions as pelvic malignancy and pelvic inflammatory disease, and premenopausal patients who wish to preserve their childbearing potential.

- END -

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DIAGNOSTIC ULTRASOUND

ISSUE DATE: November 1, 1983

AUTHORITY: 32 CFR 199.2, 32 CFR 199.4(a)(1), (b)(2), (b)(3), (b)(4), and (g)(36)

I. CPT¹ PROCEDURE CODE RANGES

Diagnostic Ultrasound: 76506 - 76778, 76801 - 76886

Ultrasonic Guidance: 76930 - 76965

Ultrasound Other: 76970 - 76999

II. DESCRIPTION

The visualization of deep structures of the body by recording the reflections (echoes) of pulses of ultrasonic waves direct into the tissues. Ultrasound is used for diagnostic and guidance purposes.

III. POLICY

A. Ultrasound procedures for diagnosis, guidance, and post-operative evaluation of surgical procedures may be cost-shared.

B. Maternity related ultrasound. Professional and technical components of medically necessary fetal ultrasounds are covered outside the maternity global fee. The medically necessary indications include (but are not limited to) clinical circumstances that require obstetric ultrasounds to: estimate gestational age, evaluate fetal growth, conduct a biophysical evaluation for fetal well being, evaluate a suspected ectopic pregnancy, define the cause of vaginal bleeding, diagnose or evaluate multiple gestations, confirm cardiac activity, evaluate maternal pelvic masses or uterine abnormalities, evaluate suspected hydatidiform mole, and evaluate the fetus' condition in late registrants for prenatal care.

C. Bone Density studies (CPT¹ procedure code 76977) are covered for:

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

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 2.1

DIAGNOSTIC ULTRASOUND

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.

IV. EXCLUSIONS

A. Ultrasound for routine screening for breast disease.

B. Ultrasound performed to determine sex of an unborn child.

C. Bone density studies for routine screening for osteoporosis.

D. Ultrasound, spinal canal and contents (CPT² procedure code 76800) for spinal scanning in adults for inflammatory conditions of the spine and nerve roots or as guidance for facet joint or epidural injections (CPT² procedure codes 76880 and 76942).

E. 3D and 4D **rendering** (CPT² procedure codes 76376 and 76377) **with maternity ultrasound** is unproven.

- END -

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