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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 79
6010.54-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM)

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 2008

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): Changes to the TRICARE Policy Manual to implement several policy determinations on evolving health care technologies including off-labeled use of Rituximab. Added coverage for proven treatment for endoscopic thoracic sympathectomy; laparoscopic and percutaneous radiofrequency ablation, CT angiography; PET and PET CT; and computed tomographic colonography. Excluded coverage for unproven treatment for Stretta system, spenopalatine block, Allopmar and dermoscopy for early detection of malignant cutaneous lesions).

EFFECTIVE DATE: As per date on individual issuance.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.


Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Branch

ATTACHMENT(S): 46 PAGE(S)
DISTRIBUTION: 6010.54-M

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 1

Section 3.1, page 1

Section 3.1, page 1

CHAPTER 4

Section 8.1, page 1

Section 8.1, pages 1 and 2

Section 13.1, page 1

Section 13.1, page 1

Section 14.1, pages 1 and 2

Section 14.1, pages 1 and 2

Section 20.1, pages 1 through 4

Section 20.1, pages 1 through 4

CHAPTER 5

Section 1.1, pages 1 through 5

Section 1.1, pages 1 through 7

Section 3.1, pages 3 through 5

Section 3.1, pages 3 through 5

Section 4.1, pages 1 through 3

Section 4.1, pages 1 through 3

CHAPTER 6

Section 1.1, pages 1 through 3

Section 1.1, pages 1 through 3

CHAPTER 7

Table of Contents, page iii

Table of Contents, page iii

Section 2.1, pages 1, 2, and 5 through 11

Section 2.1, pages 1, 2, and 5 through 11

Section 2.2, pages 1 through 6

Section 2.2, pages 1 through 7

★ ★ ★ ★ ★ ★

Section 25.1, page 1

INDEX

pages 5 and 6

pages 5 and 6

RARE DISEASES

ISSUE DATE: May 18, 1994

AUTHORITY: 32 CFR 199.2(b) and 32 CFR 199.4(g)(15)

I. DESCRIPTION

TRICARE defines a rare disease as any disease or condition that affects less than 200,000 persons in the United States.

II. POLICY

A. Coverage for treatment of rare diseases may be considered on a case-by-case basis. Case-by-case review is not required for drugs, devices, medical treatments, and procedures that have already been established as safe and effective for treatment of rare diseases.

B. In reviewing the case, any or all of the following sources may be used to determine if the proposed benefit is considered safe and effective.

1. Trials published in refereed medical literature.
2. Formal technology assessments.
3. National medical policy organization positions.
4. National professional associations.
5. National expert opinion organizations.

C. If case review indicates that the proposed benefit for a rare disease is safe and effective for that disease, benefits may be allowed. If benefits are denied, an appropriate appealing party may request an appeal.

D. Off-label use of rituximab may be considered for cost-sharing for the treatment of recurrent nodular CD20 positive lymphocyte predominant Hodgkin's disease. The effective date is January 1, 2003.

- END -

RESPIRATORY SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

30000 - 32488, 32491, 32500 - 32999, 96570, 96571

II. DESCRIPTION

The respiratory system is comprised of the tubular and cavernous organs and structures by means of which pulmonary ventilation and gas exchange between ambient air and the blood are brought about.

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the respiratory system are covered.

B. Resection of pneumatoceles is a covered procedure.

C. Lung Volume Reduction Surgery (LVRS) is a covered procedure, see [Chapter 4, Section 8.2](#).

D. Endoscopic thoracic sympathectomy (CPT¹ procedure code 32664) is covered for treatment of severe primary hyperhidrosis when appropriate nonsurgical therapies have failed and the hyperhidrosis results in significant functional impairment.

IV. EXCLUSIONS

Pillar palatal implant system for the treatment of Obstructive Sleep Apnea (OSA) is unproven.

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V. EFFECTIVE DATE

December 1, 2006, for endoscopic thoracic sympathectomy for severe primary hyperhidrosis.

- END -

DIGESTIVE SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

40490 - 40831, 40899 - 43644, 43651 - 43761, 43800, 43810, 43820, 43842, 43846 43848, 43880, 43999, 44005 - 47362, 47371, 47379, 47381, 47399 - 49999, 91123, 96570, 96571

II. DESCRIPTION

The digestive system involves the organs associated with the ingestion, digestion, and absorption of nutrients, and the elimination of solid waste.

III. POLICY

Services and supplies required in the diagnosis and treatment of illness or injury involving the digestive system are covered.

IV. EXCLUSIONS

A. Vestibuloplasty except for adjunctive care (CPT¹ procedure code range 40840-40845).

B. Percutaneous interstitial thermal ablation in the treatment of hepatic cancer is unproven.

C. **The Stretta System (Curon Medical, Sunnyvale, CA) and Bard Endoscopic Suturing System for the treatment of refractory Gastro-Intestinal Reflux Disease (GIRD) is unproven (CPT¹ procedure codes 0008T, 0133T, 43201, and 43257; C9701, C9703, and C9704).**

D. For bariatric procedures, see [Section 13.2](#).

- END -

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URINARY SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

50010 - 53899, 64561, 64581, 64585, 64590, 64595

II. DESCRIPTION

The urinary system involves those organs concerned in the production and excretion of urine.

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the urinary system are covered.

B. Benefits may be considered for the implantation of similar FDA approved devices. The Sacral Nerve Root Stimulation (SNS) has received FDA approval. Services and supplies related to the implantation of the SNS may be covered for individuals with urge incontinence, nonobstructive urinary retention, or symptoms of urgency-frequency syndrome that is not due to a neurologic condition, who have failed previous conservative treatments, and who have had a successful peripheral nerve evaluation test.

C. The use of a bedwetting alarm for the treatment of primary nocturnal enuresis may be considered for cost sharing when prescribed by a physician and after physical or organic causes for nocturnal enuresis have been ruled out.

D. Collagen implantation of the urethra and/or bladder neck may be covered for patients not amenable to other forms of urinary incontinence treatment.

E. Cryoablation for renal cell carcinoma (CPT¹ procedure codes 50250 and 50542) may be considered for coverage under the Rare Disease policy ([Chapter 1, Section 3.1](#)) on a case-by-case basis. Effective June 1, 2006.

F. Under the provisions for the treatment of rare diseases, coverage of laparoscopic radiofrequency ablation (CPT¹ procedure code 50542) and percutaneous radiofrequency

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ablation (CPT² procedure code 50592) may be considered on a case-by-case basis for the treatment of Renal Cell Carcinoma (RCC) and genetic syndromes associated with RCC including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma for patients who are not appropriate candidates for surgical intervention.

IV. EXCLUSIONS

A. Peri-urethral Teflon injection is unproven.

B. Silastic gel implant.

C. Acrylic prosthesis (Berry prosthesis).

D. Bladder stimulators, direct or indirect, such as spinal cord, rectal and vaginal electrical stimulators, or bladder wall stimulators. Payment for any related service or supply, including inpatient hospitalization primarily for surgical implementation of a bladder stimulator.

E. Transurethral balloon dilation of the prostate (CPT² procedure code 52510) is unproven.

F. Laparoscopic radiofrequency ablation (CPT² procedure code 50542) and percutaneous radiofrequency ablation (CPT² procedure code 50592) for renal masses/tumors are unproven.

V. EFFECTIVE DATE

A. Transurethral Needle Ablation (TUNA) of the prostate is proven (CPT² procedure code 53852). Effective June 1, 2004.

B. March 28, 2007, for laparoscopic radiofrequency ablation or percutaneous radiofrequency ablation for the treatment of RCC and genetic syndromes associated with RCC, including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma.

- END -

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NERVOUS SYSTEM

ISSUE DATE: August 26, 1985

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

I. CPT¹ PROCEDURE CODES

61000 - 61626, 61680 - 61860, 61863 - 63048, 63055 - ~~64484~~, ~~64508~~ - 64999, 95961, 95962, 95970 - 95975, 95978, 95979

II. DESCRIPTION

A. The nervous system consists of the central and peripheral nervous systems. The central is comprised of the brain and spinal cord and the peripheral includes all the other neural elements. The nervous system is the organ system which along with the endocrine system, correlates the adjustments and reactions of an organism to internal and environmental conditions.

B. Therapeutic embolization is a type of procedure that is commonly performed by interventional radiologist to occlude blood vessels. A microcatheter or balloon is threaded into a vein, or artery for the purposes of embolization, blocking a pathologic vascular channel.

C. Stereotactic implantation of depth electrodes is an invasive procedure in which needle-like electrodes are implanted through burr holes in the skull into the depths of specific brain areas to localize a seizure focus in patients who are candidates for surgery or to implant a brain stimulator in the thalamus to control tremors.

D. Psychosurgery is brain surgery directed at destroying normal and healthy brain tissue in order to relieve mental and psychic symptoms that other treatment modalities such as drug therapy and psychotherapy have been ineffectual in treating, for the purpose of changing or controlling behavior.

E. The Guglielmi Detachable Coil (GDC) is an extremely fine wire made from platinum, one of the softest metals, at the end of a longer stainless steel wire. In a controlled manner, the surgeon uses a micro-catheter to thread each coil through blood vessels to the aneurysm site. Application of a very-low-voltage electric current detaches and releases the coil into the aneurysm. Once in place, the GDC coils fill the aneurysm, isolating it from circulation to reduce the likelihood of rupture and hemorrhagic stroke. By applying a low voltage direct

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current to a stainless steel wire at the base of the coil, the platinum coil is detached. This applied current not only detaches the coil but also promotes electrothrombosis within the aneurysm.

III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the nervous system are covered.

B. Therapeutic embolization (CPT² procedure code 61624) may be covered for the following indications. 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. Cerebral Arteriovenous Malformations.
2. Vein of Galen Aneurysm.
3. Inoperable or High-Risk Intracranial Aneurysms.
4. Dural Arteriovenous Fistulas.
5. Meningioma.

C. Implantation of depth electrodes is covered. Implantation of a FDA approved vagus nerve stimulator as adjunctive therapy in reducing the frequency of seizures in adults and adolescents over 12 years of age, which are refractory to anti-epileptic medication is covered. Battery replacement is also covered.

D. Spinal cord and deep brain stimulation are covered in the treatment of chronic intractable pain. Coverage includes:

1. The accessories necessary for the effective functioning of the covered device.
2. Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

E. The GDC may be cost-shared for embolizing unruptured intracranial aneurysms that, because of their morphology, their location, or the patient's general medical condition, are considered by the treating neurosurgical team to be:

1. Very high risk for management by traditional operative techniques; or
2. Inoperable; or

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3. For embolizing other vascular malformation such as arteriovenous malformations and arteriovenous fistulae of the neurovasculature, to include arterial and venous embolizations in the peripheral vasculature.

IV. EXCLUSIONS

A. N-butyl-2-cyanoacrylate (Histacryl Bleu®), iodinated poppy seed oils (e.g., Ethiodol®), and absorbable gelatin sponges are not FDA approved.

B. Transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders is unproven.

C. Deep brain neurostimulation in the treatment of insomnia, depression, anxiety, and substance abuse is unproven.

D. Psychosurgery is not in accordance with accepted professional medical standards and is not covered.

E. Endovascular GDC treatment of wide-necked aneurysms and rupture is unproven.

F. Cerebellar stimulators/pacemakers for the treatment of neurological disorders are unproven.

G. Dorsal root entry zone (DREZ) thermocoagulation or microcoagulation neurosurgical procedure is unproven.

H. Epidural steroid injections for thoracic pain are unproven.

I. Extraoperative electrocortigraphy for stimulation and recording in order to determine electrical thresholds of neurons as an indicator of seizure focus is unproven.

J. Neuromuscular electrical stimulation for the treatment of denervated muscles is unproven.

K. Stereotactic cingulotomy is unproven.

L. Sacral nerve neurostimulator (CPT³ procedure codes 64561, 64581, 64585, 64590, and 64595). See [Chapter 4, Section 14.1](#) for coverage policy for the urinary system and the Sacral Nerve Root Stimulation (SNS).

M. Laminoplasty, cervical with decompression of the spinal cord, two or more vertebral segments with reconstruction of the posterior bony elements (CPT³ procedure codes 63050 and 63051).

N. Balloon angioplasty, intracranial, percutaneous (CPT³ procedure code 61630) is unproven. Effective January 1, 2006.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 4, SECTION 20.1

NERVOUS SYSTEM

O. Transcatheter placement of intravascular stent(s) intracranial, (e.g., atherosclerotic stenosis) including angioplasty, if performed (CPT⁴ procedure code 61635) is unproven. Effective January 1, 2006.

P. Balloon dilation of intracranial vasospasm, initial vessel (CPT⁴ procedure code 61640) each additional vessel in same family (CPT⁴ procedure code 61641) or different vascular family (CPT⁴ procedure code 61642) is unproven. Effective January 1, 2006.

Q. Sphenopalatine ganglion block (CPT⁴ procedure code 64505) for the treatment of chronic migraine headaches and neck pain is unproven.

V. EFFECTIVE DATES

A. January 1, 1989, for PAVM.

B. April 1, 1994, for therapeutic embolization for treatment of meningioma.

C. July 14, 1997, for GDC.

D. The date of FDA approval of the embolization device for all other embolization procedures.

E. June 1, 2004, for Magnetoencephalography.

- END -

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DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

ISSUE DATE: March 7, 1986

AUTHORITY: 32 CFR 199.4(a), (b), (c), and (e)(14) and 32 CFR 199.6(d)(2)

I. CPT¹ PROCEDURE CODES

70010 - 72285, 73000 - 76083, 76086 - 76394, 76400, 76496 - 76499, 95965 - 95967, 0145T - 0151T

II. HCPCS PROCEDURE CODES

G0204 - G0207

III. DESCRIPTION

Radiology is the science that deals with the use of radiant energy, such as X-rays, radium, and radioactive isotopes, in the diagnosis and treatment of disease. Radiology is an important diagnostic tool useful for the evaluation. The techniques used for diagnostic radiology are as follows:

A. Magnetic Resonance Imaging (MRI), formerly also referred to as Nuclear Magnetic Resonance (NMR), is a non-invasive method of graphically representing the distribution of water and other hydrogen-rich molecules in the human body. MRI uses radio frequency radiation in the presence of a carefully controlled magnetic field to produce high quality cross-sectional images of the head and body in any plane. These tomographic images represent the tissue being analyzed and the environment surrounding it. MRI has become a useful diagnostic imaging modality that is capable of demonstrating a wide variety of soft-tissue lesions with contrast resolution equal or superior to Computerized Tomography (CT) scanning in various parts of the body. Among the advantages of MRI are the absence of ionizing radiation and the ability to achieve high levels of tissue contrast resolution without injected iodinated contrast agents.

B. Magnetic Resonance Angiography (MRA) techniques generate contrast between flowing blood and surrounding tissue, and provide anatomic images that can be provided in a format similar to that of conventional x-ray angiography, and can also provide physiologic information.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

C. A Computerized Tomography (CT)/Computerized Axial Tomography (CAT) scan is interchangeably referred to as either a CT or CAT scan. This diagnostic test uses x-ray technology to create three-dimensional, computerized images of internal organs. However, unlike a traditional x-ray, CT/CAT scans are able to distinguish between obscured and overlapping parts of the body. CAT scans are also capable of producing images of several different internal components, including soft tissue, blood vessels and bones.

IV. POLICY

A. MRI and MRI with contrast media are covered when medically necessary, appropriate, and the standard of care. (CPT² procedure codes 70336, 70540-70543, 70551-70553, 71550-71552, 72141-72158, 72195-72197, 73218-73223, 73718-73723, 74181-74183, 75552-75556, and 76400.)

B. Breast MRI (CPT² procedure codes 77058 and 77059) is covered for the following indications:

1. To detect breast implant rupture (the implantation of the breast implants must have been covered by TRICARE).
2. For detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography.
3. For presurgical planning for locally advanced breast cancer before and after completion of neoadjuvant chemotherapy, to permit tumor localization and characterization.
4. For presurgical planning to evaluate the presence of multicentric disease in patients with locally advanced cancer who are candidates for breast conservation treatment.
5. Evaluation of suspected cancer recurrence.
6. To determine the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor.

NOTE: For policy on breast MRI to screen for breast cancer in high risk women, see [Chapter 7, Sections 2.1 and 2.2](#).

C. Open MRI and Open MRI with contrast media are covered when medically necessary, appropriate, and the standard of care.

D. MRA is covered when medically necessary, appropriate and the standard of care. (CPT² procedure codes 70544-70549, 71555, 72159, 72198, 73225, 73725, and 74185.)

E. 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. (CPT² procedure codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74175, 75635, and 76355-76380.)

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

F. TRICARE considers three-dimensional (3D) rendering (CPT³ procedure codes 76376 and 76377) medically necessary under certain circumstances (see [Chapter 5, Section 2.1](#)).

G. Helical (spiral) CT scans, with or without contrast enhancement, are covered when medically necessary, appropriate and the standard of care.

H. Chest x-rays (CPT³ procedure codes 71010-71035) are covered.

I. Diagnostic mammography (CPT³ procedure codes 76090-76092/HCPCS codes G0204-G0207) to further define breast abnormalities or other problems is covered.

J. 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.

K. Bone density studies (CPT³ 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.

L. Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance (CPT³ procedure code 72291) or under CT guidance (CPT³ procedure code 72292) is covered.

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M. Multislice or multidetector row CT angiography (CPT⁴ codes 0145T - 0151T) 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 performed or is equivocal.
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 resting 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 Coronary Artery Disease (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 (Single Photon Emission Computed Tomography (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).

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

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.
- C. MRIs (CPT⁵ 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 (CPT⁵ procedure codes 77058 and 77059) to assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable.
- E. 3D rendering (CPT⁵ procedure codes 76376 and 76377) for monitoring coronary artery stenosis activity in patients with angiographically confirmed CAD is unproven.
- F. 3D rendering (CPT⁵ procedure codes 76376 and 76377) for evaluating graft patency in individuals who have undergone revascularization procedures is unproven.
- G. 3D rendering (CPT⁵ 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 (CPT⁵ procedure codes 76376 and 76377) for acute ischemic stroke is unproven.
- I. CT angiography (CPT⁵ procedure codes 76376 and 76377) for intracerebral aneurysm and subarachnoid hemorrhage is unproven.
- J. CT, heart, without contrast, including image post processing and quantitative evaluation of coronary calcium (ultra fast or electron beam CT) (CPT⁵ procedure code 0144T, HCPCS code S8092) is excluded for symptomatic patients and for screening asymptomatic patients for CAD.
- K. CT, heart, without contrast material followed by contrast, material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology (CPT⁵ procedure code 0145T) is excluded for patients with typical anginal chest pain with high suspicion for CAD; patients with acute Myocardial Infarction (MI); and for screening asymptomatic patients for CAD.
- L. Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of

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coronary calcium (CPT⁶ procedure code 0146T) 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.

M. Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluation of coronary calcium (CPT⁶ procedure code 0147T) 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. Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) without quantitative evaluation of coronary calcium (CPT⁶ procedure code 0148T) 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.

O. Cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) with quantitative evaluation of coronary calcium (CPT⁶ procedure code 0149T) 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.

P. Cardiac structure and morphology in congenital heart disease (CPT⁶ procedure code 0150T) 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.

Q. CT, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing, function evaluation (left and right ventricular function, ejection fraction and segmental wall motion (CPT⁶ procedure code 0151T)) 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.

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

S. Radiological supervision and interpretation of percutaneous vertebroplasty (CPT⁶ procedure codes 72291 and 72292).

T. Dual Energy X-Ray Absorptiometry (DXA) composition study (CPT⁶ 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.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 1.1

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

- B. March 31, 2006, for breast MRI.
- C. March 31, 2006, for coverage of multislice or multidetector row CT angiography.
- D. March 1, 2007, for CPT⁷ procedure codes 72291 and 72292.

- END -

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5. Prostate cancer.
6. Meningioma.
7. Low grade glioma (astrocytoma, grade I-II).
8. Glioblastoma multiforme.
9. Soft tissue sarcoma (liposarcoma).
10. Hodgkin's disease when conventional radiotherapy is contraindicated.
11. Acoustic neuromas.

F. Helium ion beam radiosurgery/radiotherapy is covered for the following indications. This 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. As primary therapy for patients with melanoma of the uveal tract, with no evidence of metastasis or extrascleral extension, and with tumors up to 24 mm in largest diameter and 14 mm in height.

2. As postoperative therapy in patients who have undergone biopsy or partial resection of the chordoma or low grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine.

G. Extracranial stereotactic radiosurgery/radiotherapy is covered for the following indication. This 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. Primary and metastatic lung carcinoma.

H. Frameless stereotaxy (neuronavigation) is covered for the following indications. This 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. Localization, surgical planning and guidance for intracranial tumors, skull base tumors, metastatic brain tumors, AVMs, cavernomas, chordomas, and pituitary adenomas.

2. Biopsy guidance.
3. Cerebrospinal fluid shunt placement.
4. Surgery for intractable epilepsy.
5. Spinal surgery.

I. The frameless stereotaxy device must be FDA-approved. The following devices are FDA-approved: StealthStation System, The Operating Arm, ISG Viewing Wand, MKM System, and Philips Easyguide. Other systems which are FDA-approved are also covered.

IV. EXCLUSIONS

A. Whole body hyperthermia in the treatment of cancer is unproven. Hyperthermia for recurrent breast current is unproven.

B. Helium ion beam radiosurgery/radiotherapy for arteriovenous malformations and ependymoma is unproven.

C. Intra-Operative Radiation Therapy (IORT) is unproven.

D. High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking (CPT² procedure code 77422) is unproven.

E. High energy neutron radiation treatment delivery, single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking one or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s) (CPT² procedure code 77423) is unproven.

F. Compensator-based Intensity Modulated Radiation Therapy (IMRT) beam modulation treatment delivery of inverse planned treatment (0073T) is unproven.

V. EFFECTIVE DATES

A. February 26, 1986, for proton beam radiosurgery/radiotherapy for arteriovenous malformations.

B. March 1, 1988, for proton beam radiosurgery/radiotherapy for patients with Cushing's disease or acromegaly caused by pituitary microadenoma.

C. October 6, 1988, for gamma beam (gamma knife) radiosurgery/radiotherapy for treatment of arteriovenous malformation, benign brain tumors, acoustic neuromas, pituitary adenomas, craniopharyngiomas, other tumors of the posterior fossa and pineal region tumors.

D. January 1, 1990, for proton beam radiosurgery/radiotherapy for soft tissue sarcoma (liposarcoma).

E. June 18, 1990, for proton beam radiosurgery/radiotherapy for chordomas or chondrosarcomas.

F. January 1, 1994, for gamma beam (gamma knife) and linear accelerator radiosurgery/radiotherapy for metastatic brain tumors.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 3.1

RADIATION ONCOLOGY

- G. January 1, 1996, for proton beam radiosurgery/radiotherapy for uveal melanoma.
- H. January 1, 1996, for helium ion beam radiosurgery/radiotherapy for uveal melanoma and chordomas or chondrosarcomas.
- I. April 1, 1996, for linear accelerator radiosurgery/radiotherapy for arteriovenous malformations and acoustic neuromas.
- J. April 26, 1996, for proton beam radiosurgery/radiotherapy for prostate cancer.
- K. October 1, 1997, for gamma knife radiosurgery/radiotherapy for high grade gliomas (glioblastoma multiforme, anaplastic astrocytomas).
- L. January 1, 1998, for extracranial stereotactic radiosurgery/radiotherapy for lung carcinoma.
- M. The date of FDA approval for frameless stereotaxy.

- END -

NUCLEAR MEDICINE

ISSUE DATE: June 30, 1993

AUTHORITY: 32 CFR 199.4(b)(2)(vii) and (c)(2)(ix)

I. CPT¹ PROCEDURE CODE RANGE

78000 - 79999

II. DESCRIPTION

Nuclear Medicine uses very small amounts of radioactive materials or radiopharmaceuticals to diagnose and treat disease. Radiopharmaceuticals are substances that are attracted to specific organs, bones, or tissues. The radiopharmaceutical used in nuclear medicine emit gamma rays that can be detected externally by gamma or PET cameras. These cameras work in conjunction with computers used to form images that provide data and information about the area of body being imaged. The following techniques are used in the diagnosis, management, treatment, and prevention of disease: (1) Planar, Single Photon Emission Computed Tomography (SPECT); (2) Positron Emission Tomography (PET); (3) Tomography; (4) Nuclear Medicine Scan; (5) Radiopharmaceutical; (6) Gamma Camera; (7) In Vitro done in test tubes; and (8) In Vitro done in patients.

III. POLICY

A. Positron emission tomography (PET) is covered for:

1. The diagnosis and management of seizure disorders.
2. Evaluation of ischemic heart disease.
3. The diagnosis and management of lung cancer.
4. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of lymphoma.
5. PET and PET/CT for the diagnosis, staging, restaging, and monitoring of treatment of pancreatic cancer.

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6. PET scans for other indications are covered when documented by reliable evidence as safe, effective and comparable or superior to standard care (proven).

B. Single Photon Emission Computed Tomography (SPECT) is covered for:

1. Myocardial perfusion imaging utilizing SPECT.
2. Brain imaging utilizing SPECT for the evaluation of seizure disorder.
3. Prostatic radioimmunoscinigraphy imaging utilizing SPECT for the following indications:
 - a. Metastatic spread of prostate cancer and for use in post-prostatectomy patients in whom there is a high suspicion of undetected cancer recurrence.
 - b. Newly diagnosed patients with biopsy-proven prostate cancer at high risk for spread of their disease to pelvic lymph nodes.
4. Indium¹¹¹ - for detecting the presence and location of myocardial injury in patients with suspected myocardial infarction.
5. Indium¹¹¹ - labeled anti-TAG72 for tumor recurrence in colorectal and ovarian cancer.
6. SPECT for other indications is covered when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

C. Indium¹¹¹ Pentetreotide (Octreoscan) Scintigraphy is covered for:

1. The localization and monitoring of treatment of primary and metastatic neuroendocrine tumors.
2. Other indications when documented by reliable evidence as safe, effective, and comparable or superior to standard care (proven).

D. Bone Density Studies (CPT² procedure codes 78350, 78351) are covered for:

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:

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 5, SECTION 4.1

NUCLEAR MEDICINE

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.

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.

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.**

- END -

GENERAL

ISSUE DATE:

AUTHORITY: 32 CFR 199.4(a)(1)(i), (b)(2)(ix), (b)(3)(vi), (c)(2)(x) and (g)(60)

I. CPT¹ PROCEDURE CODES

80048 - 87622, 87640, 87641, 87650 - 87999, 88104 - 89264, 89330 - 89399

II. DESCRIPTION

A. Pathology is the medical science and specialty practice that deals with all aspects of disease, but with special reference to the essential nature, the causes, and development of abnormal conditions, as well as the structural and functional changes that result from disease processes.

B. The surgical pathology services include accession, examination, and reporting for a specimen which is defined as tissue that is submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. These codes require gross and microscopic examination.

III. POLICY

A. Pathology and laboratory services are covered except as indicated.

B. Surgical pathology procedures, billed by a pathologist, are covered services.

C. If the operating surgeon bills for surgical pathology procedures, they will be denied as incidental, since the definitive (microscopic) examination will be performed later, after fixation of the specimen, by the pathologist who will bill separately.

D. Dermatologists are qualified to perform surgical pathology services. Therefore, if a dermatologist bills for both the surgical procedure (e.g. CPT¹ procedure code 11100, skin biopsy) as well as the surgical pathology, both procedures are covered in full.

E. Human papillomavirus testing (CPT¹ procedure codes 87620 - 87622) is covered for the assessment of women with Atypical Squamous Cells of Undetermined Significance (ASCUS) cells detected upon initial pap smear.

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F. For Transfusion Services refer to [Chapter 6, Section 2.1](#).

IV. EXCLUSIONS

A. Autopsy and postmortem (CPT² procedure codes 88000-88099).

B. Sperm penetration assay (hamster oocyte penetration test or the zona-free hamster egg test) is excluded for IVF (CPT² procedure code 89329).

C. In-vitro chemoresistance and chemosensitivity assays (stem cell assay, differential staining cytotoxicity assay and thymidine incorporation assay) are unproven.

D. Hair analysis to identify mineral deficiencies from the chemical composition of hair is unproven. Hair analysis testing (CPT² procedure code 96902) may be reimbursed when necessary to determine lead poisoning.

E. Insemination of oocytes (CPT² procedure code 89268).

F. Extended culture of oocyte(s) embryo(s) 4-7 days (CPT² procedure code 89272).

G. Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes (CPT² procedure code 89280).

H. Assisted oocyte fertilization, microtechnique; greater than 10 oocytes (CPT² procedure code 89281).

I. Biopsy oocyte polar body or embryo blastomere (CPT² procedure code 89290).

J. Biopsy oocyte polar body or embryo blastomere; greater than 4 embryos (CPT² procedure code 89291).

K. Cryopreservation reproductive tissue, testicular (CPT² procedure code 89335).

L. Storage (per year) embryo(s) (CPT² procedure code 89342).

M. Storage (per year) sperm/semen (CPT² procedure code 89343).

N. Storage (per year) reproductive tissue, testicular/ovarian (CPT² procedure code 89344).

O. Storage (per year) oocyte (CPT² procedure code 89346).

P. Thawing of cryopreserved, embryo(s) (CPT² procedure code 89352).

Q. Thawing of cryopreserved, sperm/semen, each aliquot (CPT² procedure code 89353).

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 6, SECTION 1.1

GENERAL

R. Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT³ procedure code 89354).

S. Thawing of cryopreserved, oocytes, each aliquot (CPT³ procedure code 89356).

T. CPT³ procedure codes 83701, and 83704 and not covered for Low Density Lipoprotein (LDL) subclass testing.

U. Allo Map[™] for molecular testing is unproven for use in cardiac transplant rejection surveillance.

- END -

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002
CHAPTER 7 - MEDICINE

SECTION	SUBJECT
22.1	Telemedicine/Telehealth
	FIGURE 7-22.1-1 -Telehealth Originating Site Facility Fee
23.1	Augmentative Communication Devices (ACD)
24.1	Phase II And Phase III Cancer Clinical Trials
25.1	Dermoscopy

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, 77058, 77059, 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 AND TEMPORARY PROCEDURE CODES

A. Level II Codes G0104, 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 (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, Papanicolaou (Pap) smears, and mammograms. The NDAA FY 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 Health Maintenance Organization (HMO) Benefit (see [32 CFR 199.18\(b\)\(2\)](#)), except for the application of appropriate cost-sharing and deductibles under Extra and Standard plans.

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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 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. 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.

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(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) 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 three to five years beginning at age 50. The effective date for coverage of proctosigmoidoscopy or sigmoidoscopy is October 6, 1997.

(4) Optical (Conventional) 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 two years beginning at age 25, or five 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 three to five years beginning 10 years earlier than the youngest affected relative.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

(b) The effective date for coverage of colonoscopy for individuals at increased risk 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.

(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.

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.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

(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% 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.

(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); 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 homepage (<http://www.cdc.gov>) for a current schedule of CDC recommended vaccines. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006. The effective date of coverage for the zoster vaccine is October 19, 2007.

(b) Coverage is extended 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;

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

(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 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., CPT⁵ 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 (CPT⁵ 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.

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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.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.1

CLINICAL PREVENTIVE SERVICES - TRICARE STANDARD

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 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 mammographies 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
SCREENING EXAMINATIONS:		
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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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

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 76083 and 76092 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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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

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: 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.
Colorectal Cancer:	Physical Examination: Digital rectal examination should be included in the periodic health examination of individuals 40 years of age and older.	See appropriate level evaluation and management codes.
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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	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 immunochemical-based testing is August 20, 2003.	CPT ¹ codes 82270 and 82274.
	Proctosigmoidoscopy or Sigmoidoscopy: Once every three to five years beginning at age 50.	CPT ¹ codes 45300-45321, 45327, and 45330-45339. HCPCS code G0104.
	Optical (Conventional) Colonoscopy for Individuals at Average Risk for Colon Cancer: Once every 10 years for individuals age 50 or above. The effective date for coverage of colonoscopy for individuals at average risk is March 15, 2006.	CPT ¹ codes 45355 and 45378-45385. HCPCS codes G0105 and G0121.
	Optical (Conventional) Colonoscopy for Individuals at Increased Risk for Colon Cancer: Performed every two years beginning at age 25, or five years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier and then annually after age 40 for individuals with hereditary non-polyposis colorectal cancer syndrome. Individuals with familial risk of sporadic colorectal cancer (i.e., individuals with first degree relatives with sporadic colorectal cancer or adenomas before the age 60 or multiple first degree relatives with colorectal cancer or adenomas) may receive a colonoscopy every three to five years beginning at age 10 years earlier than the youngest affected relative.	

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

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. The effective date for coverage of CTC for this indication is March 15, 2006. CTC is NOT covered as a colorectal cancer screening for any other indication or reason.	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 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: females, once, age 12-18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.	CPT ¹ code 86762.
	Hepatitis B Screening: Screen pregnant women for HBsAG during prenatal period.	CPT ¹ code 87340.
Cardiovascular Diseases:	Cholesterol: Non-fasting total blood cholesterol: At least once every five years, beginning age 18.	CPT ¹ code 80061.

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

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 and/or ophthalmologist.		

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 2.2

CLINICAL PREVENTIVE SERVICES - TRICARE PRIME

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	Hearing Screening: For children: all high risk neonates (as defined by the Joint Committee on Infant Hearing) audiology screening before leaving the hospital. If not tested at birth, high-risk children should be screened before three months of age. Evaluate hearing of all children as part of routine examinations and refer those with possible hearing impairment as appropriate.	CPT ¹ codes 92551, 92587, and 92588.
	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 6 years. Screening by blood lead level determination for all children at high risk for lead exposure per CDC guidelines.	CPT ¹ code 83655.
COUNSELING SERVICES:		
These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.	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.	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.
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. The effective date of coverage for the Human Papilloma Virus (HPV) vaccine is October 13, 2006. The effective date of coverage for the zoster vaccine is October 19, 2007.	

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- END -

DERMOSCOPY

ISSUE DATE: June 19, 2008

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

I. CPT¹ PROCEDURE CODES

96904

II. DESCRIPTION

Early phases of malignant melanoma can be difficult to detect. Surgery (i.e., biopsy) to remove the melanoma is the standard treatment for this disease. However, a number of surveillance technologies have been developed in an attempt to improve accuracy in diagnosing malignancies in pigmented skin lesions without using a biopsy or excision (removal) of the lesion itself.

Dermoscopy (also known as Digital Epiluminescence Microscopy (DELM), dermatoscopy, melanomography, in vivo cutaneous surface microscopy, mole mapping, and magnified oil immersion diascopy) is one of technologies designed for detecting and monitoring dysplastic and atypical nevi for early detection of malignant cutaneous melanomas. The dermoscope allows 10x or higher magnification by using high intensity light. Oil placed between the skin and the lens makes the skin more transparent and enables visualization of skin structures to the bottom of the outermost layer of the skin. This technology offers the physician the ability to have a baseline image to refer to so he or she can examine each suspicious lesion, and then compare them year after year, by re-imaging.

III. POLICY

The Dermoscopy technique for diagnosing and monitoring dysplastic and atypical nevi for early detection of malignant cutaneous melanoma in patients with suspicious pigmented skin lesions is not covered because it is considered unproven.

- END -

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INDEX

CHAPTER

SECTION

C (Continued)

Custodial Care Transitional Policy (CCTP)

8

15.1

INDEX	CHAPTER	SECTION
D		
DD 1251 (Sample)	1	6.1
Delivery Of Health Care At Military Treatment Facilities (MTFs)	1	6.1
Dental Anesthesia And Institutional Benefit	8	13.2
Department Of Veterans Affairs And Department Of Defense Health Care Resources Sharing	1	12.1
Dermatological Procedures - General	7	17.1
I Dermoscopy	7	25.1
Diabetes Outpatient Self-Management Training Services	8	8.1
Diagnostic Genetic Testing	6	3.1
Diagnostic Mammography	5	1.1
Diagnostic Radiology (Diagnostic Imaging)	5	1.1
Diagnostic Sleep Studies	7	19.1
Diagnostic Ultrasound	5	2.1
Dialysis	7	4.2
Digestive System	4	13.1
Donor Costs	4	24.9
Durable Medical Equipment	8	2.1