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**CHANGE 172
6010.57-M
OCTOBER 13, 2016**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR
TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

The Defense Health Agency has authorized the following addition(s)/revision(s).

CHANGE TITLE: PREVENTIVE SERVICES ENHANCEMENTS

CONREQ: 18050

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates and clarifies TRICARE's preventive policies to achieve greater parity with the Patient Protection & Affordable Care Act based on the USPSTF and HRSA recommendations.

EFFECTIVE DATE: As Stated in the Issuance.

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1.1.18 Services and supplies provided under circumstances or in geographic locations requiring a Non-Availability Statement (NAS), when such a statement was not obtained. (See [Section 6.1](#).)

1.1.19 Services or supplies which require preauthorization if preauthorization was not obtained. Services and supplies which were not provided according to the terms of the preauthorization. An exception to the requirement for preauthorization may be granted if the services otherwise would be payable except for the failure to obtain preauthorization.

1.1.20 Psychoanalysis or psychotherapy provided to a beneficiary or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may be present.

1.1.21 Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

1.1.22 Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet all TRICARE requirements for coverage are not excluded.

1.1.23 Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for or paid; except if benefits provided under such laws are exhausted.

1.1.24 Services and supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in [32 CFR 199.4\(e\)\(8\)](#) (see [Chapter 4, Section 2.1](#)).

1.1.25 Surgery performed primarily for psychological reasons (such as psychogenic) (see [Chapter 4, Section 2.1](#)).

1.1.26 Electrolysis (see [Chapter 4, Section 2.1](#)).

1.1.27 Dental care or oral surgery, except as specifically provided in [32 CFR 199.4\(e\)\(10\)](#) (see [Chapter 4, Section 7.1](#) and [Chapter 8, Section 13.1](#)).

1.1.28 Services and supplies related to obesity or weight reduction whether surgical or nonsurgical; wiring of the jaw or any procedure of similar purposes; regardless of the circumstances under which performed; except that benefits may be provided for the gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity as provided in [32 CFR 199.4\(e\)\(15\)](#) (see [Chapter 4, Section 13.2](#) and [Chapter 8, Section 7.2](#)).

1.1.29 Services and supplies related to **sex gender change, also referred to as sex reassignment surgery, are prohibited by Section 1079 of Title 10, United States Code (USC). This exclusion does not apply to surgery and related medically necessary services performed to correct ambiguous genitalia which has been documented to have been present at birth** (see [Chapter 4, Sections 15.1, 16.1, 17.1](#), and [Chapter 7, Sections 1.1 and 1.2](#)).

1.1.30 Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy, or other similar services, and any supplies provided in connection with therapy for sexual

dysfunctions, inadequacies, or paraphilic disorders (see [Chapter 4, Section 15.1](#) and [Chapter 7, Section 1.1](#)).

1.1.31 Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes (see [Chapter 8, Section 1.1](#)).

1.1.32 Treatment of dyslexia.

1.1.33 Surgery to reverse surgical sterilization procedures (see [Chapter 4, Sections 15.1](#) and [17.1](#) and [Chapter 7, Section 2.3](#)).

1.1.34 Noncoital reproductive procedures including artificial insemination, In Vitro Fertilization (IVF), gamete intrafallopian transfer and all other such assistive reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), IVF, gamete intrafallopian transfer and all other noncoital reproductive technologies (see [Chapter 4, Sections 17.1, 18.1](#) and [Chapter 7, Section 2.3](#)).

1.1.35 Nonprescription contraceptives (see [Chapter 4, Section 17.1](#) and [Chapter 7, Section 2.3](#)).

1.1.36 Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child (see [Chapter 4, Section 18.2](#) and [Chapter 5, Section 2.1](#)).

1.1.37 Preventive care, except as provided in the Clinical Preventive Services policy (see [Chapter 7, Sections 2.1, 2.2, and 2.5](#)).

1.1.38 Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider (see [Chapter 7, Section 18.5](#)).

1.1.39 Counseling services that are not medically necessary in the treatment of a diagnosed medical condition. For example, educational counseling, vocational counseling, and counseling for socioeconomic purposes, stress management, life-style modification, etc. Services provided by a certified marriage and family therapist, pastoral counselor or supervised mental health counselor in the treatment of a mental disorder are covered only as specifically provided in [32 CFR 199.6](#). Services provided by alcoholism rehabilitation counselors are covered only when rendered in a TRICARE-authorized treatment setting and only when the cost of those services is included in the facility's TRICARE-determined allowable cost rate.

Note: See [Chapter 8, Section 7.1](#) for policy on Nutritional Therapy. Diabetes Self-Management Training (DSMT) is covered (see [Chapter 8, Section 8.1](#)).

1.1.40 Acupuncture, whether used as a therapeutic agent or as an anesthetic.

1.1.41 Hair transplants, wigs (also referred to as cranial prosthesis), or hairpieces, except as allowed in accordance with section 744 of the DoD Appropriations Act for 1981 (see [Chapter 4, Section 2.1](#) and [Chapter 8, Section 12.1](#)).

1.1.42 Self-help, academic education or vocational training services and supplies, unless the provisions of [32 CFR 199.4\(b\)\(1\)\(v\)](#) relating to general or special education, apply.

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Chapter 1, Section 1.2

Exclusions

Note: See [32 CFR 199.5](#) and [Chapter 9, Section 8.1](#), for training benefits under ECHO.

1.1.43 Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items (see [Chapter 8, Section 2.1](#)).

1.1.44 General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of a comprehensive program of physical therapy (see [Chapter 7, Sections 18.2 and 18.3](#)).

1.1.45 Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of an otherwise covered benefit or treatment addressed to the physical defect itself and not to any educational or occupational defect (see [Chapter 7, Sections 7.1 and 8.1](#)).

1.1.46 Eye exercises or visual training (orthoptics) (see [Chapter 4, Section 21.1](#) and [Chapter 7, Section 6.1](#)).

1.1.47 Eye and hearing examinations except as specifically provided in [32 CFR 199.4\(b\)\(2\)\(xvi\)](#), [\(b\)\(3\)\(xi\)](#), and [\(e\)\(24\)](#) or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-child care is not excluded (see [Chapter 4, Section 21.1](#) and [Chapter 7, Sections 2.1, 2.2, 2.5, 6.1 and 8.1](#)).

1.1.48 Prostheses, other than those determined to be necessary because of significant conditions resulting from trauma, congenital anomalies, or disease. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly (see [Chapter 8, Section 4.1](#)).

1.1.49 Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up (see [Chapter 8, Sections 3.1 and 11.1](#)).

1.1.50 Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under [32 CFR 199.4\(e\)\(6\)](#) (see [Chapter 7, Section 6.2](#)).

1.1.51 Hearing aids or other auditory sensory enhancing devices except as specifically provided in [32 CFR 199.4\(e\)\(24\)](#).

1.1.52 Services or advice rendered by telephone are excluded, except that a diagnostic or monitoring procedure which incorporates electronic transmission of data or remote detection and measurement of a condition, activity, or function (biotelemetry) is not excluded when:

1.1.52.1 The procedure without electronic transmission of data or biotelemetry is otherwise an explicit or derived benefit; and

1.1.52.2 The addition of electronic transmission of data or biotelemetry to the procedure is found to be medically necessary and appropriate medical care which usually improves the efficiency of the management of a clinical condition in defined circumstances; and

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Chapter 1, Section 1.2

Exclusions

1.1.52.3 That each data transmission or biotelemetry device incorporated into a procedure that is otherwise an explicit or derived benefit of this section, has been classified by the U.S. Food and Drug Administration (FDA), either separately or as a part of a system, for use consistent with the defined circumstances in [32 CFR 199.4\(g\)\(52\)\(ii\)](#).

Note: See [Chapter 7, Section 22.1](#) for policy on Telemental Health (TMH)/Telemedicine.

1.1.53 Air conditioners, humidifiers, dehumidifiers, and purifiers.

1.1.54 Elevators or chair lifts.

1.1.55 Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

1.1.56 Items of clothing or shoes, even if required by virtue of an allergy.

1.1.57 Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care, except as specifically covered (see [Chapter 8, Sections 7.1 and 7.2](#)).

1.1.58 Enuretic conditioning programs.

1.1.59 Autopsy and postmortem (see [Chapter 6, Section 1.1](#)).

1.1.60 All camping even though organized for a specific therapeutic purpose, and even though offered as a part of an otherwise covered treatment plan or offered through an approved facility.

1.1.61 Housekeeping, homemaker, or attendant services, sitter or companion (for exceptions, see [32 CFR 199.4\(e\)\(19\)](#) regarding hospice care) (see the TRICARE Reimbursement Manual (TRM), [Chapter 11, Sections 1 and 4](#)).

1.1.62 All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

1.1.63 Personal, comfort, or convenience items, such as beauty and barber services, radio, television, and telephone (for exceptions, see [32 CFR 199.4\(e\)\(19\)](#) regarding hospice care).

Note: Admission kits are covered.

1.1.64 Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

1.1.65 All transportation except by ambulance, as specifically provided under [32 CFR 199.4\(d\)](#) and [\(e\)\(5\)](#).

Note: Transportation of an institutionalized ECHO beneficiary to or from a facility or institution to receive authorized ECHO services or items may be cost-shared under [32 CFR 199.5\(c\)\(6\)](#). Transportation of an accompanying medical attendant to ensure the safe transport of the ECHO beneficiary may also be cost-shared (see [Chapter 9, Section 11.1](#)).

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Chapter 1, Section 1.2

Exclusions

1.1.66 All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in [32 CFR 199.4\(a\)\(6\)](#).

Note: For the exception for certain Prime travel expenses and non-medical attendants, see [32 CFR 199.17\(n\)\(2\)\(vi\)](#) and the TRM, [Chapter 1, Section 30](#).

1.1.67 Services and supplies provided by other than a hospital, unless the institution has been approved specifically by TRICARE. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities.

1.1.68 Service animals (Seeing Eye dogs, hearing/handicap assistance dogs, seizure and other detection animals, service monkeys, etc.) are excluded from coverage under the Basic or ECHO programs.

- END -

Maternity Care

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)\(i\)](#), [\(e\)\(16\)](#), [\(g\)\(5\)](#), [\(g\)\(34\)](#), and [\(g\)\(36\)](#)

1.0 CPT¹ PROCEDURE CODES

59000 - 59899, 82105, 82106, 82731, 84702

2.0 DESCRIPTION

Maternity care is the medical services related to conception, delivery and pregnancy loss, including prenatal and postpartum care (generally through the sixth post-delivery week), and treatment of complications of pregnancy.

3.0 POLICY

3.1 Services and supplies associated with antepartum care (including well-being of the fetus), childbirth, postpartum care, and complications of pregnancy may be cost-shared.

3.2 The maternity care benefit includes, but is not limited to, the following prenatal screening tests:

3.2.1 Anemia Screening.

3.2.2 Asymptomatic Bacteriuria, Urinary Tract, or Other Infection Screening. Screen with urine culture for women 12-16 weeks gestation, or at first prenatal visit, if later.

3.2.3 Gestational Diabetes Mellitus Screening. Screen women 24-28 weeks pregnant and those at high risk of developing gestational diabetes.

3.2.4 Hepatitis B Screening. Screen pregnant women for HBsAG during the prenatal period.

3.2.5 Human Immunodeficiency Virus (HIV) Infection Screening.

3.2.6 Rh Incompatibility Screening. Screen all pregnant women and provide follow-up testing for pregnant women at high risk.

3.2.7 Syphilis Infection Screening.

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3.2.8 Other screening tests as recommended by the United States Preventive Services Task Force.

3.3 Genetic testing is considered preventive rather than active medical treatment. However, under the family planning benefit, genetic testing, including testing done as part of routine prenatal care, is covered when performed in certain high risk situations. For the purpose of the TRICARE benefit, genetic testing may include specific tests to detect developmental abnormalities as well as tests for specific genetic defects.

3.4 The mother and child hospital length-of-stay (LOS) benefit may not be restricted to less than 48 hours following a normal vaginal delivery and 96 hours following a cesarean section. The decision to discharge prior to those minimum LOSs must be made by the attending physician in consultation with the mother.

3.5 Maternity care for pregnancy resulting from noncoital reproductive procedures may be cost-shared. Where the contractual arrangements do not specify an amount for reimbursement for medical expenses, the full amount of all undesignated payments shall be deemed to be for medical expenses incurred by the surrogate mother. TRICARE will cost-share on the remaining balance of otherwise covered benefits related to the surrogate mother's medical expenses after the contractually agreed upon arrangement has been exhausted.

3.6 For pregnancies in which the TRICARE beneficiary is a surrogate mother, services and supplies associated with antepartum care, childbirth, postpartum care, and complications of pregnancy may be cost-shared.

3.7 Tocolysis is a covered benefit. The off-label use of U.S. Food and Drug Administration (FDA) approved drugs are subject to requirements specified in [Chapter 8, Section 9.1, paragraph 2.2.6](#). 17 alpha-hydroxyprogesterone caproate for prevention of preterm delivery is covered.

3.8 Progesterone therapy for the prevention of preterm birth is covered only when the following criteria are met:

3.8.1 Weekly injections of 17 alpha-hydroxyprogesterone caproate between 16 and 36 weeks of gestation for pregnant women with a documented history of a previous spontaneous birth at less than 37 weeks of gestation.

3.8.2 Oral progesterone therapy or injections of 17 alpha-hydroxyprogesterone caproate are **NOT** covered for other high risk factors for preterm birth, including, but not limited to multiple gestations, short cervical length, or positive fetal tests for cervicovaginal fetal fibronectin.

4.0 EXCLUSIONS

4.1 Services and supplies related to noncoital reproductive procedures.

4.2 Home Uterine Activity Monitoring (HUAM), telephonic transmission of HUAM data, or HUAM-related telephonic nurse or physician consultation for the purpose of monitoring suspected or confirmed pre-term labor is unproven.

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Chapter 4, Section 18.1

Maternity Care

4.3 Subcutaneous terbutaline pump and home use of maintenance subcutaneous terbutaline to suppress labor is unproven.

4.4 Lymphocyte or paternal leukocyte immunotherapy in the treatment of recurrent spontaneous fetal loss is unproven.

4.5 Salivary estriol test for preterm labor is unproven (CPT² procedure code 82677).

- END -

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Chapter 7

Medicine

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1.2	Gender Dysphoria
2.1	Clinical Preventive Services - TRICARE Standard
2.2	Clinical Preventive Services - TRICARE Prime
2.3	Family Planning
2.4	Cervical Cancer Screening
2.5	Well-Child Care
2.6	Chelation Therapy
2.7	Hydration, Therapeutic, Prophylactic, And Diagnostic Injections And Infusions
3.1	Acute Hospital Psychiatric Care: Preauthorization, Concurrent Review, and Payment Responsibility
3.2	Residential Treatment Center (RTC) Care: Preauthorization and Concurrent Review
3.3	Preauthorization Requirements For Substance Use Disorder (SUD) Detoxification And Rehabilitation
3.4	Psychiatric Partial Hospitalization Programs (PHPs) - Preauthorization And Day Limits
3.5	Substance Use Disorders (SUDs)
3.6	Specific Learning Disorders
3.7	Attention-Deficit/Hyperactivity Disorder
3.8	Treatment Of Mental Disorders
3.9	Ancillary Inpatient Mental Health Services
3.10	Psychological Testing
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3.12	Family Therapy
3.13	Psychotropic Pharmacologic Management
3.14	Collateral Visits
3.15	Eating Disorder Treatment
3.16	Applied Behavior Analysis (ABA)

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Chapter 7, Medicine

Section/Addendum	Subject/Addendum Title
3.17	Applied Behavior Analysis (ABA) For Non- Active Duty Family Members (NADFM) Who Participate In The ABA Pilot
4.1	Biofeedback
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5.1	Gastroenterology
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6.2	Lenses (Intraocular Or Contact) And Eye Glasses
6.3	Cardiovascular Therapeutic Services
7.1	Speech Services
8.1	Special Otorhinolaryngologic Services
8.2	Hearing Aids And Hearing Aid Services
9.1	Electronystagmography (ENG)
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16.2	Health And Behavior Assessment/Intervention
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17.1	Dermatological Procedures - General
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18.2	Physical Medicine/Therapy
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18.5	Chiropractic Manipulative Treatment (CMT)
19.1	Diagnostic Sleep Studies
20.1	Hyperbaric Oxygen (HBO) Therapy
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Section/Addendum	Subject/Addendum Title
22.1	Telemental Health (TMH)/Telemedicine
23.1	Augmentative Communication Devices (ACDs)
24.1	Phase I, Phase II, And Phase III Cancer Clinical Trials
25.1	Dermoscopy
26.1	Forensic Examinations Following Sexual Assault or Domestic Violence
27.1	Botulinum Toxin Injections

Clinical Preventive Services - TRICARE Standard

Issue Date: April 19, 1983

Authority: [32 CFR 199.4\(e\)\(28\)](#) and [\(f\)\(12\)](#), 10 USC 1079(a), [Public Law 110-471, Section 711](#)

1.0 CPT¹ PROCEDURE CODES

45300 - 45305, 45308 - 45315, 45320, 45321, 45330, 45331, 45333, 45338, 45346, 45378, 45380, 45384, 45385, 45388, 74263, 76977, 77052, 77057 - 77059, 77078 - 77081, 80061, 81528, 82270, 82274, 82465, 82947 - 82952, 83036, 83718 - 83721, 84152 - 84154, 84478, 85013 - 85027, 86480, 86481, 86580, 86592, 86593, 86631, 86632, 86689, 86701 - 86706, 86762, 86780, 86803, 86804, 87110, 87270, 87320, 87340, 87341, 87389 - 87391, 87490 - 87492, 87534 - 87536, 87590 - 87592, 87623 - 87625, 87800, 87801, 87806, 87810, 87850, 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, 88175, 92002, 92004, 92012, 92014, 92015, 99172, 99173, 99383 - 99387, 99393 - 99397, 99401 - 99404

2.0 HCPCS PROCEDURE CODES

Level II Codes G0101 - G0105, G0121, [G0123](#), [G0124](#), [G0130](#), [G0141](#) - [G0148](#), G0202, [G0328](#), [G0445](#), [G0472](#), [G6022](#), [G6024](#)

3.0 POLICY

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

The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009 (Public Law 110-417, Section 711) waived cost-share requirements for certain preventive services rendered on or after October 14, 2008. (See the TRICARE Reimbursement Manual (TRM), [Chapter 2, Section 1](#), [paragraphs 1.3.3.10](#) and [1.4.3](#) for services for which cost-shares were eliminated.)

Effective January 1, 2017, cost-shares are also eliminated for the services listed in [paragraphs 3.1.1.1.2](#) and [3.1.5](#).

Covered services as identified in this policy are based on recommendations from the United States Department of Health and Human Services (HHS). This includes recommendations from the United States Preventive Services Task Force, the Health Resources and Services Administration, etc.

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

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care policy. (See [Section 2.5](#).)

A 30 day administrative tolerance will be allowed for any time interval requirements imposed on services covered by this policy; e.g., if an asymptomatic woman 40 years of age or older received a screening mammography on September 15, coverage for another screening mammography would be allowed on or after August 17 of the following year.

3.1 Covered Services Exempt from Cost-Share Requirements

The following preventive services are covered and exempt from cost-share requirements under Standard and Extra plans:

3.1.1 Cancer Screening Examinations and Services

3.1.1.1 Breast Cancer

3.1.1.1.1 Clinical Breast Examination (CBE)

A CBE may be performed during a covered [Health Promotion and Disease Prevention](#) examination.

3.1.1.1.2 BRCA1 Or BRCA2 Genetic Counseling And Testing

3.1.1.1.2.1 Genetic counseling rendered by a TRICARE-authorized provider that precedes BRCA1 or BRCA2 gene testing is covered for women who are identified as high risk for breast cancer by their primary care clinician.

3.1.1.1.2.2 BRCA1 or BRCA2 gene testing is covered for women who meet the coverage guidelines outlined in the TRICARE Operations Manual (TOM), [Chapter 18, Section 17, Figure 18.17-1](#).

3.1.1.1.3 Screening Mammography

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

3.1.1.1.3.2 Screening mammography is covered annually beginning at age 30, for women who have a 15% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:

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

3.1.1.1.3.2.2 Extremely dense breasts when viewed by mammogram;

3.1.1.1.3.2.3 Known BRCA1 or BRCA2 gene mutation;

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

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

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

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

3.1.1.1.4 Breast Magnetic Resonance Imaging (MRI)

3.1.1.1.4.1 Breast MRI is covered annually, in addition to the annual screening mammogram, beginning at age 30, and at age 35 for services rendered prior to September 7, 2010, for women who have a 20% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:

3.1.1.1.4.1.1 Known BRCA1 or BRCA2 gene mutation;

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

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

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

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

3.1.1.2 Cervical Cancer

3.1.1.2.1 Pelvic Examination

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

3.1.1.2.2 Pap Smears

3.1.1.2.2.1 For dates of service prior to May 8, 2015, cancer screening Pap smears should be performed for women who are at risk for sexually transmissible diseases, women who have or have had multiple sexual partners (or if their partner has or has had multiple sexual partners), women who smoke cigarettes, and women 18 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Director, **Defense Health Agency (DHA)**. The frequency of the Pap smears will be at the discretion of the patient and clinician but not less frequent than every three years.

3.1.1.2.2.2 For dates of service on or after May 8, 2015, cancer screening Pap smears are covered for female beneficiaries beginning at age 21. Women under age 21 should not be screened

regardless of the age of sexual initiation or other risk factors. The frequency of screening Pap smears may be at the discretion of the patient and clinician; however, screening Pap smears should not be performed less frequently than once every three years.

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

3.1.1.2.3.1 HPV DNA testing is covered as a cervical cancer screening only when performed in conjunction with a Pap smear, and only for women aged 30 and older.

3.1.1.2.3.2 To be eligible for reimbursement as a cervical cancer screening, HPV DNA testing must be billed in conjunction with a Pap smear that is provided to a woman aged 30 or older.

3.1.1.3 Colorectal Cancer

3.1.1.3.1 The following cancer screenings and frequencies are covered for individuals at **average risk** for colon cancer:

- Fecal Occult Blood Testing (FOBT). Either guaiac-based or immunochemical-based testing of three consecutive stool samples once every 12 months for beneficiaries who have attained age 50 (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was done).
- Fecal Immunochemical Testing (FIT-DNA). FDA approved stool DNA tests (e.g., Cologuard™) once every three years beginning at age 50.
- Proctosigmoidoscopy or Flexible Sigmoidoscopy. Once every three to five years beginning at age 50.
- Computed Tomographic Colonography (CTC). Once every five years beginning at age 50.
- Optical (Conventional) Colonoscopy. Once every 10 years beginning at age 50.

3.1.1.3.2 A family history of colorectal cancer or adenomatous polyps increases an individual's risk of colon cancer. The following identifies these risk factors and the cancer screenings and frequencies covered for individuals at **increased risk** for colon cancer:

- One or more first-degree relatives diagnosed with sporadic colorectal cancer or an adenomatous polyp before the age of 60 or in two or more first-degree relatives at any age. Optical colonoscopy should be performed every three to five years beginning at age 40 or 10 years earlier than the youngest affected relative, whichever is earlier.
- One or more first-degree relatives diagnosed with sporadic colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colon cancer. Either flexible sigmoidoscopy (once every five years) or optical colonoscopy (once every 10 years) should be performed beginning at age 40.

3.1.1.3.3 Certain other risk factors put an individual at **high risk** for colon cancer. The following identifies these risk factors and the cancer screenings and frequencies covered for individuals at **high risk** for colon cancer:

- Individuals with known or suspected Familial Adenomatous Polyposis (FAP). Annual flexible sigmoidoscopy beginning at age 10 to 12.
- Family history of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) syndrome. Optical colonoscopy should be performed once every one to two years beginning at age 20 to 25, or 10 years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier.
- Individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease. For these individuals, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.

Note: The risk factors identified above for colorectal cancer are those established by the American Cancer Society.

3.1.1.4 Prostate Cancer

3.1.1.4.1 Rectal Examination

Digital rectal examination will be offered annually for all men beginning at age 50 who have at least a 10 year life expectancy. It should also be offered to begin for men age 45 and over with a family history of prostate cancer in at least one other first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65) and to all African American men aged 45 and over regardless of family history. Testing should be offered to start at age 40 for men with a family history of prostate cancer in two or more other family members.

3.1.1.4.2 Prostate-Specific Antigen (PSA)

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

- Men aged 50 years and older.
- Men aged 45 years and over with a family history of prostate cancer in at least one other family member.
- African American men aged 45 and over regardless of family history.
- Men aged 40 and over with a family history of prostate cancer in two or more other family members.

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

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

3.1.1.5 Other

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

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

3.1.1.5.2 Skin Cancer Screening. Examination of the skin should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.

3.1.1.5.3 Oral Cavity and Pharyngeal Cancer Screening. A complete oral cavity examination should be part of routine preventive care for adults at **high risk** due to exposure to tobacco or excessive amounts of alcohol.

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

3.1.2 Immunizations

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

- The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) for use in the United States; and
- The ACIP adopted recommendations have been accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC **Morbidity and Mortality Weekly Report** (MMWR).
- The effective date of coverage for CDC recommended vaccines is the date ACIP recommendations for the vaccine are published in a MMWR.

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

3.1.2.3 Immunizations recommended specifically for travel outside the United States are NOT covered, EXCEPT for immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service. **Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.**

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

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

3.1.4 Well Woman Examinations

HP&DP exams for the purpose of a well woman exam are covered annually for female beneficiaries under age 65. If the primary care clinician determines that a patient requires additional well woman visits to obtain all necessary recommended preventive services that are age and developmentally appropriate, these may be provided without cost-sharing and subject to reasonable medical management. There is no requirement that a well woman exam (HP&DP exam) be rendered in connection with a covered cancer screening or immunization.

3.1.5 Other Screenings And Services

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

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

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

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

3.1.5.4 Hepatitis C Virus (HCV) Screening. Screen for HCV in individuals at **high risk** for infection and as a one-time screening for adults born between 1945 and 1965.

3.1.5.5 Diabetes Mellitus (Type II) Screening. Screen adults with a sustained blood pressure (treated or untreated) greater than 135/80 mmHg. Screen adults aged 40-70 who are overweight or obese.

3.1.5.6 Human Immunodeficiency Virus (HIV) Infection Screening. Screen for HIV in individuals ages 15-65. Younger adolescents and older adults who are at **increased risk** should also be screened.

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

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

3.1.5.9 Cholesterol Screening. Screen children once between the ages of 9 and 11 and again between the ages of 17 and 21. Screen men age 35 and older. Screen men and women age 20 and older who are at **increased risk** for coronary heart disease.

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

3.1.5.11 Osteoporosis Screening. Screen women for osteoporosis whose fracture risk is equal to or greater than that of a 65 year old white woman who has no additional risk factors.

3.1.5.12 Intensive Behavioral Counseling for Sexually Transmitted Infections (STIs). Intensive behavioral counseling (counseling that lasts more than 30 minutes) for all sexually active individuals who are at **increased risk** for STIs is covered when rendered by a TRICARE authorized provider.

3.1.5.13 For prenatal screening tests, see [Chapter 4, Section 18.1](#).

3.2 Covered Services Not Exempt From Cost-Sharing Requirements

Regular Standard and Extra plan cost-sharing requirements apply to the following services:

3.2.1 School Physicals

Physical examinations required in connection with school enrollment are covered.

3.2.2 Physical Examinations Required for Travel Outside the United States - Orders Required

A physical examination provided when required in the case of a family member who is traveling outside the United States as a result of the member's assignment and such travel is being performed under orders issued by a Uniformed Service is covered. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.

3.2.3 Routine Eye Examinations

One routine eye exam per calendar year per person is covered for family members of Active Duty Service Members (ADSMs) under Standard and Extra plans. Routine eye exams under Standard and Extra plans are excluded for retirees and their family members. Please see [Section 6.1](#).

Note: Routine eye exams are meant to be more than the standard visual acuity screening test conducted by the member's primary care physician through the use of a standard Snellen wall chart.

Note: Routine eye exams for diabetic beneficiaries are covered as a medically necessary service and shall be adjudicated as such, rather than as a preventive benefit.

3.2.4 Audiology Screening

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

3.3 Other

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

3.3.1 Counseling

Patient and parent education and counseling for:

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

3.3.2 Body Measurements

For adults, height and weight is typically measured and Body Mass Index (BMI) calculated at each primary care visit. Individuals identified with a BMI of 25 or above typically receive appropriate nutritional and physical activity counseling as part of the primary care visit. For children and adolescents, height and weight typically is measured and BMI-for-age calculated and plotted at each primary care visit using the CDC "Data Table of BMI-for-age Charts". Children/adolescents with a BMI value greater than the 85th percentile typically receive appropriate nutritional and physical activity counseling as part of the primary care visit.

4.0 EFFECTIVE DATES

4.1 The NDAA for FY 2009 (Public Law 110-417, Section 711) waived cost-share requirements for certain preventive services rendered on or after October 14, 2008. (See the TRM, [Chapter 2, Section 1, paragraphs 1.3.3.10 and 1.4.3](#) for services for which cost-shares were eliminated.)

4.2 Effective January 1, 2017, cost-shares are also eliminated for the services outlined in [paragraphs 3.1.1.1.2 and 3.1.5](#).

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

- END -

Clinical Preventive Services - TRICARE Prime

Issue Date: May 15, 1996
Authority: [32 CFR 199.17](#)

1.0 POLICY

1.1 TRICARE Prime enrollees may receive Prime Clinical Preventive Services from any network provider within their region of enrollment without referral or authorization. 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 Primary Care Manager (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 contractor 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.

1.2 There shall be no copayments 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 Current Procedural Terminology (CPT) procedure code is individually reimbursable. A 30 day administrative tolerance will be allowed for any time interval requirements imposed on **services covered by this policy**, e.g., if an asymptomatic woman 40 years of age or older received a screening mammography on September 15, coverage for another screening mammography would be allowed on or after August 17 of the following year.

1.3 The services identified in this policy are applicable to beneficiaries six years of age and older. Health Promotion and Disease Prevention (HP&DP) annual examinations for those beneficiaries age 6-21 include those services recommended by the American Academy of Pediatrics and Bright Futures guidelines. This includes developmental observation, physical examination, screening, immunizations, and anticipatory guidance. For beneficiaries under age six, covered preventive services are identified in the TRICARE well-child care policy. See [Section 2.5](#).

1.4 Covered services as identified in this policy are based on recommendations from the United States Department of Health and Human Services (HHS). This includes recommendations from the United States Preventive Services Task Force, the Health Resources and Services Administration, etc. For the benefits under this program, the effective date of coverage is the publication date of the corresponding recommendation from the HHS.

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Chapter 7, Section 2.2

Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
HEALTH PROMOTION AND DISEASE PREVENTION (HP&DP) EXAMINATIONS	For ages six years and older: One HP&DP examination is covered annually.	CPT ¹ codes 99383 - 99387 and 99393 - 99397.
WELL WOMAN EXAMINATIONS	HP&DP exams for the purpose of a well woman exam are covered annually for female beneficiaries under age 65. If the primary care clinician determines that a patient requires additional well woman visits to obtain all necessary recommended preventive services that are age and developmentally appropriate, these may be provided without copay and subject to reasonable medical management.	CPT ¹ codes 99383 - 99386 and 99393 - 99396.
TARGETED CLINICAL PREVENTIVE SERVICES	The following clinical preventive services may be performed during either an HP&DP exam or a well woman exam .	
Breast Cancer:	Clinical Breast Examination (CBE): A CBE may be performed during a covered HP&DP exam.	See appropriate level evaluation and management codes and HCPCS code G0101 .
	BRCA1 or BRCA2 Genetic Counseling and Testing: Genetic counseling rendered by a TRICARE-authorized provider that precedes BRCA1 or BRCA2 gene testing is covered for women who are identified as high risk for breast cancer by their primary care clinician.	CPT ¹ codes 99401 - 99404.
	BRCA1 or BRCA2 gene testing is covered for women who meet the coverage guidelines outlined in the TRICARE Operations Manual (TOM), Chapter 18, Section 17, Figure 18.17-1 .	
	Screening Mammography: Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors: 1. History of breast cancer, Ductal Carcinoma In Situ (DCIS), Lobular Carcinoma In Situ (LCIS), Atypical Ductal Hyperplasia (ADH), or Atypical Lobular Hyperplasia (ALH); 2. Extremely dense breasts when viewed by mammogram; 3. Known BRCA1 or BRCA2 gene mutation; 4. First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves; 5. Radiation therapy to the chest between the ages of 10 and 30 years; or	CPT ¹ codes 77052 and 77057. HCPCS codes G0202.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Breast Cancer (Continued):	6. History of Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with a history of one of these syndromes.	
	Note: The risk factors identified above for screening mammography are those established by the American Cancer Society.	
	Breast Screening Magnetic Resonance Imaging (MRI): Covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors: 1. Known BRCA1 or BRCA2 gene mutation; 2. First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves; 3. Radiation to the chest between the ages of 10 and 30; or 4. History of LiFraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with a history of one of these syndromes.	CPT ¹ codes 77058 and 77059.
	Note: The risk factors identified above for breast cancer screening MRI are those established by the American Cancer Society.	
Cervical Cancer:	Pelvic Examination: A pelvic examination should be performed as part of a well woman exam and in conjunction with Pap smear testing for cervical neoplasms and premalignant lesions.	See appropriate level evaluation and management codes and HCPCS code G0101.
	Pap Smears: For dates of service prior to May 8, 2015, cancer screening Pap smears should be performed for women who are at risk for sexually transmittable diseases, women who have or have had multiple sexual partners (or if their partner has or has had multiple sexual partners), women who smoke cigarettes, and women 18 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Director, Defense Health Agency (DHA). The frequency of the screening Pap smears will be at the discretion of the patient and clinician but not less frequent than every three years. For dates of service on or after May 8, 2015, cancer screening Pap smears are covered for female beneficiaries beginning at age 21. Women under age 21 should not be screened regardless of the age of sexual initiation or other risk factors. The frequency of screening Pap smears may be at the discretion of the patient and clinician; however, screening Pap smears should not be performed less frequently than once every three years.	CPT ¹ codes 88141 - 88155, 88160 - 88162, 88164 - 88167, 88174, and 88175. HCPCS codes G0123, G0124, and G0141 - G0148.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Cervical Cancer (Continued):	<p>Human Papillomavirus (HPV) Deoxyribonucleic Acid (DNA) Testing: HPV DNA testing is covered as a cervical cancer screening only when performed in conjunction with a Pap smear, and only for women aged 30 and older.</p> <p>To be eligible for reimbursement as a cervical cancer screening, HPV DNA testing must be billed in conjunction with a Pap smear that is provided to a woman aged 30 or older.</p>	CPT ¹ codes 87623-87625.
Colorectal Cancer:	<p>The following cancer screenings and frequencies are covered for individuals at average risk for colon cancer:</p> <p>Fecal Occult Blood Testing (FOBT): Either guaiac-based or immunochemical-based testing of three consecutive stool samples once every 12 months for beneficiaries who have attained age 50 (i.e., at least 11 months must have passed following the month in which the last covered screening fecal-occult blood test was done).</p> <p>Fecal Immunochemical Testing (FIT-DNA): FDA approved stool DNA tests (e.g., Cologuard™) once every three years beginning at age 50.</p> <p>Proctosigmoidoscopy or Flexible Sigmoidoscopy: Once every three to five years beginning at age 50.</p> <p>Computed Tomographic Colonography (CTC): Once every five years beginning at age 50.</p> <p>Optical (Conventional) Colonoscopy: Once every 10 years beginning at age 50.</p> <p>A family history of colorectal cancer or adenomatous polyps increases an individual's risk of colon cancer. The following identifies these risk factors and the cancer screenings and frequencies covered for individuals at increased risk for colon cancer:</p> <p>One or more first-degree relatives diagnosed with sporadic colorectal cancer or an adenomatous polyp before the age of 60 or in two or more first-degree relatives at any age. Optical colonoscopy should be performed every three to five years beginning at age 40 or 10 years earlier than the youngest affected relative, whichever is earlier.</p> <p>One or more first-degree relatives diagnosed with sporadic colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colon cancer. Either flexible sigmoidoscopy (once every five years) or optical colonoscopy (once every 10 years) should be performed beginning at age 40.</p>	<p>CPT¹ codes 82270 and 82274. HCPCS code G0328.</p> <p>CPT¹ code 81528</p> <p>CPT¹ codes 45300 - 45305, 45308 - 45315, 45320, 45321, 45330, 45331, 45333, 45338, and 45346. HCPCS code G0104 and G6022.</p> <p>CPT¹ code 74263</p> <p>CPT¹ codes 45378, 45380, 45384, 45385, and 45388. HCPCS codes G0105, G0121, and G6024.</p>

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	<p>Optical (Conventional) Colonoscopy (Continued):</p> <p>Certain other risk factors put an individual at high risk for colon cancer. The following identifies these risk factors and the cancer screenings and frequencies covered for individuals at high risk for colon cancer:</p> <p>Individuals with known or suspected Familial Adenomatous Polyposis (FAP). Annual flexible sigmoidoscopy beginning at age 10 to 12.</p> <p>Family history of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) syndrome. Optical colonoscopy should be performed once every one to two years beginning at age 20 to 25, or 10 years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier.</p> <p>Individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease. For these individuals, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.</p>	
	<p>Note: The risk factors identified above for colorectal cancer are those established by the American Cancer Society</p>	
Prostate Cancer:	<p>Rectal Examination: Digital rectal examination will be offered annually for all men beginning at age 50 who have at least a 10 year life expectancy. It should also be offered to begin for men age 45 and over with a family history of prostate cancer in at least one other first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65) and to all African American men aged 45 and over regardless of family history. Testing should be offered to start at age 40 for men with a family history of prostate cancer in two or more other family members.</p>	See appropriate level evaluation and management codes and HCPCS code G0102.
	<p>Prostate-Specific Antigen (PSA): Annual testing for the following categories of males may be offered:</p> <ol style="list-style-type: none"> 1. Men aged 50 years and older. 2. Men aged 45 years and over with a family history of prostate cancer in at least one other family member. 3. 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. <p>A discussion between the beneficiary and his provider on the risks/benefits of PSA testing is encouraged.</p> <p>Screening may continue to be offered as long as the individual has a 10 year life expectancy.</p>	CPT ¹ codes 84152 - 84154. HCPCS code G0103.

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Testicular Cancer:	Physical Examination: Examination of the testis should be performed annually for males age 13-39 with a history of cryptorchidism, orchiopexy, or testicular atrophy.	See appropriate level evaluation and management codes.
Skin Cancer:	Physical Examination: Examination of the skin should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.	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.	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.
Lung Cancer:	Low-Dose Computed Tomography: Screening covered annually for persons 55 through 80 years of age with a 30 pack per year history of smoking who are currently smoking or have quit within the past 15 years. Screening should be discontinued once the individual has not smoked for 15 years or develops a health problem significantly limiting either life expectancy or ability or willingness to undergo curative lung surgery.	CPT ¹ code 71250. HCPCS code G0297.
Immunizations:	<p>Coverage is extended for the age appropriate dose of vaccines that meet the following requirements:</p> <ol style="list-style-type: none"> 1. The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) for use in the United States; and 2. The ACIP adopted recommendations have been accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC Morbidity and Mortality Weekly Report (MMWR). 3. The effective date of coverage for CDC recommended vaccines is the date ACIP recommendations for the vaccine are published in an MMWR. <p>Refer to the CDC's web site (http://www.cdc.gov) for a current schedule of CDC recommended vaccines for use in the United States.</p> <p>Immunizations recommended specifically for travel outside the United States are NOT covered, EXCEPT for immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.</p>	

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Infectious Diseases:	Tuberculosis (TB) Screening: Screen annually, regardless of age, all individuals at high risk for tuberculosis (as defined by the CDC using Mantoux tests.	CPT ¹ codes 86480, 86481, and 86580.
	Rubella Antibodies: Test females, once, between the ages of 12 and 18, unless documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday is documented.	CPT ¹ code 86762.
	Hepatitis B Virus (HBV) Screening: Screen for HBV in individuals at high risk for infection.	CPT ¹ codes 86704 - 86706, 87340, and 87341.
	Hepatitis C Virus (HCV) Screening: Screen for HCV in individuals at high risk for infection and as a one-time screening for adults born between 1945 and 1965.	CPT ¹ codes 86803 and 86804. HCPCS code G0472.
	Human Immunodeficiency Virus (HIV) Infection Screening: Screen for HIV in individuals ages 15-65. Younger adolescents and older adults who are at increased risk should also be screened.	CPT ¹ codes 86689, 86701 - 86703, 87389 - 87391, 87534 - 87536, and 87806.
	Syphilis Infection Screening: Screen at risk individuals for syphilis infection.	CPT ¹ codes 86592, 86593, and 86780.
	Chlamydia and Gonorrhea Screening: Screen sexually active women age 24 years and younger and older women who are at increased risk for infection.	CPT ¹ codes 86631, 86632, 87110, 87270, 87320, 87490 - 87492, 87590 - 87592, 87800, 87801, 87810, and 87850.
Diabetes Mellitus (Type II):	Diabetes Mellitus (Type II) Screening: Screen adults with a sustained blood pressure (treated or untreated) greater than 135/80 mmHg. Screen adults aged 40-70 who are overweight or obese.	CPT ¹ codes 82947 - 82952 and 83036.
Cardiovascular Diseases:	Cholesterol Screening: Screen children once between the ages of 9 and 11 and again between the ages of 17 and 21. Screen men age 35 and older. Screen men and women age 20 and older who are at increased risk for coronary heart disease.	CPT ¹ codes 80061, 82465, 83718 - 83721, and 84478.
	Blood Pressure Screening: At least every two years after age six.	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 76700 and 76775. HCPCS code G0389.
Osteoporosis:	Osteoporosis Screening: Screen women for osteoporosis whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	CPT ¹ codes 76977 and 77078 - 77081. HCPCS code G0130.
Intensive Behavioral Counseling for Sexually Transmitted Infections (STIs):	Intensive Behavioral Counseling for STIs: Intensive behavioral counseling (counseling that lasts more than 30 minutes) for all sexually active individuals who are at increased risk for STIs is covered when rendered by a TRICARE authorized provider.	CPT ¹ codes 99401 - 99404. HCPCS code G0445.

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Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Prenatal Screening Tests:	See Chapter 4, Section 18.1.	
Other:	School Physicals: Physical examinations required in connection with school enrollment are covered.	CPT ¹ codes 99383 and 99393.
	Physical Examinations Required for Travel Outside the United States – Orders Required: A physical examination provided when required in the case of a family member who is traveling outside the United States as a result of the member's assignment and such travel is being performed under orders issued by a Uniformed Service is covered. Claims must include a copy of the travel orders or other official documentation verifying the official travel requirement.	See appropriate level evaluation and management codes.
	Body Measurement: For children and adolescents: Height and weight typically is measured and Body Mass Index (BMI)-for-age calculated and plotted at each primary care visit using the CDC "Data Table of BMI-for-age Charts". Children/adolescents with a BMI value greater than the 85th percentile typically receive appropriate nutritional and physical activity counseling as part of the primary care visit. Head circumference typically is measured through age 24 months. For adults: Height and weight typically is measured and BMI calculated at each primary care visit. Individuals identified with a BMI of 25 or above typically receive appropriate nutritional and physical activity counseling as part of primary care visit.	See appropriate level evaluation and management codes.
	Vision Care: Routine eye exam once every two years for retirees and eligible family members who are enrolled in Prime. Active Duty Family Members (ADFM)s who are enrolled in Prime may receive a routine eye exam annually (see Section 6.1).	CPT ¹ codes 92002, 92004, 92012, 92014, 92015, 99172, and 99173.
	Note: Routine eye exams are meant to be more than the standard visual acuity screening test conducted by the member's primary care physician through the use of a standard Snellen wall chart. Self-referral will be allowed for routine eye exams since PCMs are incapable of providing this service (i.e., a Prime beneficiary will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist).	
	Note: Routine eye exams for diabetic beneficiaries are covered as a medically necessary service and shall be adjudicated as such, rather than as a preventive benefit.	
	Hearing Screening: A hearing evaluation should be a part of routine examinations for all children, and those with possible hearing impairment should be referred for appropriate testing.	See appropriate level evaluation and management codes.

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Chapter 7, Section 2.2

Clinical Preventive Services - TRICARE Prime

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Other (Continued):	Patient & Parent Education And Counseling: <ul style="list-style-type: none">• Accident & Injury Prevention;• Cancer surveillance;• Depression, stress, bereavement, & suicide risk assessment;• Dietary assessment & nutrition;• Intimate partner violence and abuse;• Physical activity & exercise;• Promoting dental health;• Risk reduction for skin cancer;• Safe sexual practices; and• Tobacco, alcohol and substance abuse.	These are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

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- END -

Well-Child Care

Issue Date: April 19, 1983

Authority: [32 CFR 199.4\(c\)\(2\)\(xiii\)](#) and [\(c\)\(3\)\(xi\)](#)

1.0 CPT¹ PROCEDURE CODES

54150, 54160, 54161, 81000 - 81015, 81099, 83655, 84030, 84035, 85014, 85018, 86580, 86585, 90465 - 90468, 90471 - 90474, 90476 - 90748, 92002, 92004, 92012, 92014, 92015, 92551, 92585 - 92588, 96110, 99172, 99173, 99381 - 99383, 99391 - 99393, 99460 - 99463, 99499.

2.0 DESCRIPTION

Well-child care includes routine newborn care, health supervision examinations, routine immunizations, periodic health screening, and developmental assessment in accordance with the American Academy of Pediatrics (AAP) and Bright Futures guidelines.

3.0 POLICY

Well-child care is covered for beneficiaries from birth to age six when services are provided by the attending pediatrician, family physician, ophthalmologist or optometrist, certified Nurse Practitioner (NP), or certified Physician Assistant (PA). Well-child services are considered preventive and are subject to the same cost-sharing/copayment and authorization requirements prescribed under the TRICARE Prime and Standard Clinical Preventive Services benefit (see [Sections 2.1](#) and [2.2](#)).

4.0 POLICY CONSIDERATIONS

4.1 Visits for diagnosis or treatment of an illness or injury are not included in the well-child benefit. Benefits should be extended on the basis of the medical necessity for the services.

4.2 For children whose health screening and immunizations may not be current, payment may be made for well-child visits and immunizations up to midnight of the day prior to the day the child turns six years old, and thereafter under the TRICARE Clinical Preventive Services benefit (see [Sections 2.1](#) and [2.2](#)).

4.3 Immunizations are covered for the 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 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). Refer to the CDC's web site (<http://www.cdc.gov>) for access to the MMWRs and a

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current schedule of CDC recommended vaccines. Immunizations recommended specifically for travel outside the United States are not covered. EXCEPT for immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service.

Note: The procedure codes in this policy are not necessarily an all-inclusive list of vaccines currently recommended for use in the United States by the CDC's ACIP.

4.4 Well-child care for newborns includes the routine care of the newborn in the hospital, newborn circumcision, and newborn metabolic screening as recommended by the AAP. In 2005, the AAP endorsed the newborn screening report from the American College of Medical Genetics that significantly expanded metabolic screening for newborn infants. These conditions include a core panel of 28 conditions and an additional secondary panel of 25 conditions. The most recently endorsed conditions for screening are reflected in the Department of Defense/Veteran Administration (DoD/VA) Clinical Practice Guideline. Only routine well-child care for newborns is covered as part of the mother's maternity episode, i.e., a separate cost-share is not required for the infant.

Note: Male circumcision performed during newborn period (0 - 30 days) is covered. Male circumcision performed outside the newborn period due to medical complications at birth or during the newborn period that prevented performing the circumcision within the newborn period, may be covered up to 30 days after discharge. Male circumcision performed after the newborn period without medical complications at birth, may be covered if medically necessary and otherwise authorized for benefits.

4.5 Each office visit for well-child care includes the following services:

4.5.1 History and physical examination and mental health assessment.

4.5.2 Developmental and behavioral appraisals, which may include questions about a child's language, motor, cognitive, social, and emotional development.

4.5.2.1 Height and weight should be measured regularly throughout infancy and childhood.

4.5.2.2 Head circumference should be measured for children through 24 months of age.

4.5.2.3 Sensory screening: vision, hearing (by history).

4.5.2.3.1 Eye and vision screening by primary care provider during routine examination at birth, and approximately six months of age.

4.5.2.3.2 According to the AAP and the Joint Committee on Infant Hearing (JCIH), all newborns should undergo hearing screening using evoked Otoacoustic Emissions (OAE) testing or automated Auditory Brainstem Response (ABR) testing before one month of age; preferably, before leaving the hospital. An infant who does not pass the hearing screening should undergo appropriate audiological and medical evaluations to confirm the presence of a hearing loss at no later than three months of age.

Chelation Therapy

Issue Date: October 12, 1984

Authority: [32 CFR 199.4\(c\)\(2\)\(iii\)](#), [\(d\)\(3\)\(vi\)](#), and [\(g\)\(15\)](#)

1.0 CPT¹ PROCEDURE CODE

90784

2.0 DESCRIPTION

Chelation techniques for the therapeutic or preventive effects of removing unwanted metal ions from the body.

3.0 POLICY

Chelation therapy is covered if the chelator is U.S. Food and Drug Administration (FDA) approved and the therapy is for an FDA approved indication.

4.0 EXCLUSIONS

Chelation therapy (or chemical endarterectomy) is considered an unproven therapeutic modality for the treatment of the following conditions, and is not covered:

- Multiple sclerosis
- Arthritis
- Hypoglycemia
- Diabetes
- Arteriosclerosis
- Malaria
- Cancer
- Alzheimer's disease
- Autism spectrum disorders
- Other off-label uses of FDA approved chelating agents

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Hydration, Therapeutic, Prophylactic, And Diagnostic Injections And Infusions

Issue Date:

Authority: [32 CFR 199.4\(b\)\(2\)\(v\)](#), [\(b\)\(3\)\(iii\)](#), [\(b\)\(5\)\(v\)](#), [\(d\)\(3\)\(vi\)](#), [\(e\)\(11\)\(ii\)](#), and [\(g\)\(15\)](#)

1.0 CPT¹ PROCEDURE CODES

96360 - 96379

2.0 HCPCS PROCEDURE CODES

J2357, J3487, J3488

3.0 DESCRIPTION

Intravenous (IV) hydration infusion consists of pre-packaged fluid and electrolytes, but not infusion of drugs or other substances. A therapeutic, prophylactic, or diagnostic IV infusion or injection (other than hydration) is for the administration of substances or drugs.

Note: Policy regarding chemotherapy administration is found in [Section 16.3](#).

4.0 POLICY

4.1 Hydration IV infusion consisting of a pre-packaged fluid and electrolytes is covered.

4.2 Intravenous or intra-arterial push (an injection in which the health care professional who administers the substance/drug is continuously present to administer the injection and observe the patient or an infusion of 15 minutes or less) for therapy, prophylactic, or diagnosis is covered.

4.3 Off-label use of zoledronic acid (Zometa[®]) for the treatment of breast cancer may be cost-shared when:

4.3.1 Patient was premenopausal at the time of diagnosis, and has stage I or II breast cancer;

4.3.2 Patient has had surgically induced menopause (e.g., oophorectomy) or has been put temporarily into menopause (chemically induced menopause with Goserelin or similar product) prior to administration of zoledronic acid;

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Hydration, Therapeutic, Prophylactic, And Diagnostic Injections And Infusions

4.3.3 Patient has hormone receptor (Estrogen Receptor (ER) and/or Progesterone Receptor (PR)) positive disease and zoledronic acid is being used in combination with hormonal therapy (e.g., Tamoxifen, Arimidex®, Aromasin®, Femara®);

4.3.4 No concurrent adjuvant chemotherapy has been given or planned;

4.3.5 Prescriber is an oncologist or an individual highly familiar with prescribing and monitoring of oncology-related medications.

4.3.6 Off-label use of omalizumab (Xolair®) for the treatment of chronic urticaria may be cost-shared.

5.0 EFFECTIVE DATES

5.1 February 12, 2009, for off-label use of zoledronic acid (Zometa®) for the treatment of breast cancer.

5.2 July 1, 2011, for off-label use of omalizumab (Xolair®) for the treatment of chronic urticaria.

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