

April 2021

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TRICARE Coverage of COVID-19 Vaccine

As the rollout of COVID-19 vaccines continues across the nation, you may get questions from TRICARE patients as to availability and coverage. Because the first supplies of the vaccines are limited, the Department of Defense (DoD) established a distribution plan that will be carried out in phases. While beneficiaries wait their turn to get the vaccine, be sure to encourage them to continue to practice healthy habits such as wearing a mask and practicing physical distancing.

Outside of military hospitals and clinics, TRICARE beneficiaries may receive approved COVID-19 vaccines through the civilian provider and pharmacy network, as they become available. You can direct TRICARE patients to www.tricare.mil/COVIDVaccine for details. We also offer links to state-specific resources at www.tricare-west.com/go/COVID-19.

Vaccines are a no-cost benefit covered under the clinical preventive services benefit. A separate office visit copayment may apply if other services are rendered during the visit.

TRICARE covers the following vaccines (*list subject to change as new vaccines become available*):

- Pfizer-BioNTech COVID-19 vaccine, effective Dec. 13, 2020, for ages 16 and up
- Moderna COVID-19 vaccine, effective Dec. 20, 2020, for ages 18 and up
- Janssen COVID-19 vaccine (also known as Johnson & Johnson), effective Feb. 27, 2021, for ages 18 and up

Prior authorization is not required.

To review the TRICARE COVID-19 vaccination benefit in more detail, please visit our [Benefits A–Z page](#).

Are you interested in becoming a COVID-19 vaccine provider? Find details, including the required Centers for Disease Control and Prevention (CDC) [COVID-19 Vaccination Program Provider Agreement](#). Providers enrolled in the program must monitor and comply with CDC COVID-19 Vaccination Program requirements.

COVID-19 Clinical Trials

Participation in clinical trials can offer eligible TRICARE beneficiaries more options for COVID-19 treatment and recovery support. TRICARE benefits are available to beneficiaries selected to participate in Phase I, II, III and IV National Institute of Allergy and Infectious Diseases (NIAID)-sponsored COVID-19 clinical trials. Coverage will continue through the end of the President's National Emergency.

Locating Clinical Trials

To be eligible for this TRICARE benefit, clinical trials must be NIAID-sponsored. Locate eligible clinical trials by visiting the U.S. National Library of Medicine Database at ClinicalTrials.gov and the NIAID website at www.niaid.nih.gov. If you are uncertain as to whether a particular clinical trial is NIAID-sponsored, please contact NIAID at 1-800-411-1222.

Eligibility

TRICARE beneficiaries must meet entry criteria for the clinical trial's phase of treatment. Specific to Phase I, the attending physician, primary care manager or specialist must refer the beneficiary to the trial. Only TRICARE-authorized providers may administer treatment.

Beneficiaries enrolled in an eligible COVID-19 clinical trial during the national emergency will remain covered for the duration of that clinical trial, even if the national emergency has ended, so long as TRICARE requirements are met.

Costs

Normal TRICARE eligibility, reimbursement, copayments, cost-shares, and deductibles apply.

Visit our COVID-19 resources page online at www.tricare-west.com/go/COVID19 for more information.



Buckley Prime Service Area (PSA) Pilot

Managing health care and improving health outcomes has become more critical than ever in our communities and will take new levels of collaboration and partnership to achieve. With the advancements in population health, we can now fully achieve the Military Health System's Quadruple Aim to provide better care, enhance the patient/provider experience and improve mission readiness.

On Jan. 1, 2021, HNFS launched a value-based care pilot in the Buckley Air Force Base (AFB), Colorado area, known as the "Buckley Prime Service Area (PSA) Pilot." Core to the Pilot is ensuring enhanced provider support, enhanced care programs and incentives for high-performing providers. The pilot is expected to run through Dec. 31, 2022.

There is no beneficiary enrollment or action required, and the TRICARE benefit remains the same. Beneficiaries who live in the Buckley PSA, are enrolled in TRICARE Prime and have a civilian primary care manager are automatically part of the Pilot.

- No change to the TRICARE benefit or out-of-pocket expense
- No change to the claims or referral/authorization submission process
- Same HNFS West Region customer service line and www.tricare-west.com online self-service tools



Our concierge-type customer service will help Pilot participants get to the right provider, at the right time, for the right care. This includes:

- help to locate providers
- reminders about preventive care
- chronic care education and support
- care navigation and management

Our approach to developing, maintaining and managing a robust provider network is based on understanding local community-based needs and developing collaborative partnerships with qualified providers who are motivated to serve TRICARE beneficiaries.

For more information, visit our Buckley PSA Pilot page at www.tricare-west.com/go/Buckley-provider.

Save Time: Submit Referrals and Authorizations Only When Required

As our referral and authorization volumes return to pre-pandemic levels, we want to remind you of simple guidelines to follow for your TRICARE patients. Knowing when, and when not, to submit authorization or referral requests to Health Net Federal Services, LLC (HNFS) saves you time and expedites access to care for your patients.

Did you know not all covered TRICARE services require a referral or authorization? In fact, most diagnostic laboratory tests and radiology services do not require HNFS approval. Avoid extra work by only submitting requests to HNFS if they are needed. Familiarizing yourself with the requirements is an important step in helping your TRICARE patients get the care they need without delay.

Before you submit:

1. **Have you checked requirements?** Use our [Prior Authorization, Referral and Benefit tool](#) to determine if a referral or authorization is needed. Remember, TRICARE Select patients do not require a referral for specialty care (except for applied behavior analysis, or ABA, services). And non-active duty service members who have other health insurance only require prior authorization for ABA services.
2. **Is it a limited benefit?** HNFS offers [Letters of Attestation \(LOAs\)](#) for several limited benefits. You can attach the LOA instead of clinical documentation to your online request, which will expedite the review process.
3. **Is it an ancillary service, such as diagnostic radiology or lab tests?** Our [TRICARE Ancillary Services](#) list tells you if you need an approval from HNFS. Most ancillary services do not require an approval.
4. **Do you need to change an existing authorization?** If you need to request changes, please do not contact the referring provider or military hospital or clinic. Many changes can be requested through our online [Outpatient Authorization Change Request Form](#). If your patient needs care beyond the expiration date or additional services that need HNFS approval, submit a separate, new request.

Find additional authorization and referral details on our [How to Submit](#) page.



Dual Eligibility: TRICARE and VA

In some cases, you may encounter beneficiaries eligible for benefits under both TRICARE and the U.S. Department of Veterans Affairs (VA). In this instance, they have the option to use either TRICARE or VA benefits.

What does this mean for you?

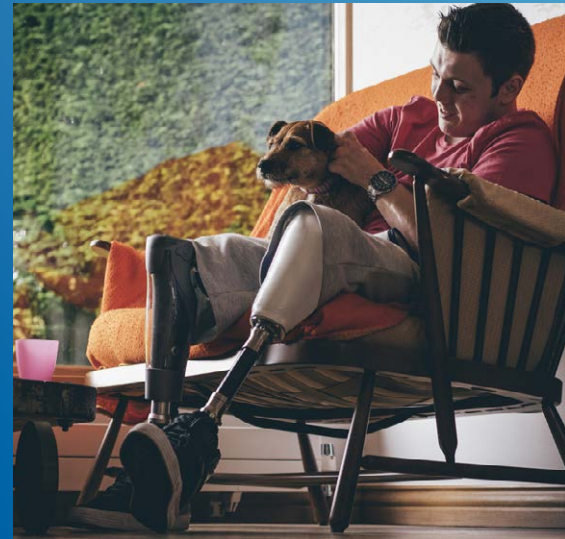
It's important to know that programs offered through the VA are not TRICARE programs, but rather unique health care programs administered by VA. In certain situations, TRICARE providers may be asked to accept requests from VA to provide care to veterans. If a provider agrees to see a VA patient, the referral and instructions for seeking reimbursement from the VA Medical Center (VAMC) will be provided prior to the time of the appointment. However, if the VA patient is also a TRICARE beneficiary and chooses to use his/her TRICARE benefits, TRICARE procedures should be followed.

If you provide care to a beneficiary who is covered by both TRICARE and VA, it is imperative that claims be submitted to one or the other, but not both.

Keep in mind:

- If eligible, patients can receive care under either TRICARE or VA.
- Once treatment has begun, the patient must continue to get care under the same program until the end of that particular episode of care.
- There is no coordination of benefits between TRICARE and VA.
- The rules and costs for the program chosen will apply.

Find more information on dual eligibility in the [TRICARE Provider Handbook](#).



Attention Internet Explorer 11 Users: Adding Attachments in CareAffiliate

CareAffiliate, our preferred referral and authorization submission tool, allows users to add attachments such as supporting medical documentation to expedite the authorization review process. Due to Adobe's support of Flash Player ending earlier this year, providers who use Internet Explorer (IE) 11 as their web browser will need to disable the "Shockwave Flash Object" application in order to continue submitting attachments in CareAffiliate. This does not apply to those who use Chrome as their web browser.

How to disable the "Shockwave Flash Object" application in IE 11:

1. In the upper right corner of your browser window, click on the tools icon.
2. Select "Manage add-ons."
3. Select "Show: All Add-ons."
4. Look for Shockwave Flash Object and select that application.
5. Click on the "Disable" button and close the window.
6. If you haven't already, log out from CareAffiliate.
7. Close and reopen your Internet Explorer browser.

Find additional information about submitting authorization and referral requests to HNFS on our [How to Submit](#) page.



Has Your Information Changed? Let Us Know!



Accurate provider data is a key component to delivering timely, quality health care. We encourage you to familiarize yourself with the options available for you to update your demographic information with us.

How do I update my address, phone number or fax number?

Use our [Update Demographics tool](#), or you may submit a [TRICARE Provider Roster](#).

What if I need to update my specialty information?

First, make sure your information is listed correctly in the [National Plan & Provider Enumeration System \(NPPES\)](#). If correct, log in to our [Update Specialty Tool](#) to request specialty changes. Exception: ABA providers updating their specialty (for example, RBT to BCaBA or BCaBA to BCBA) must submit a completed TRICARE Provider Roster.

Can I still use the Provider Information Form to make demographic updates?

In an effort to streamline our processes, HNFS has eliminated demographic updates from this form. The updated form is now only used to add new providers to an existing location (groups with more than 20 providers should use the TRICARE Provider Roster).

How do I make updates if I am a non-network provider?

Non-network providers should verify the accuracy of their information in our online [Non-Network Provider Directory](#). To make updates, submit a Non-Network Provider Information Update Request Form and/or a Non-Network Provider Specialty Update form, both available on our [Forms](#) page.

Choosing Wisely® – Asthma and Smoking

Living with a chronic lung disease like asthma makes the lungs more sensitive than people without asthma. However, about 17% of adults with asthma in the U.S. smoke, even though cigarette smoke is known to trigger asthma attacks.¹ Long-term exposure to smoke can severely impact lung function and is one of the primary triggers for asthma attacks. Smokers with asthma are more likely to require a visit to the emergency room than nonsmokers.²

Additionally, secondhand smoke is one of the most common triggers for asthma sufferers because it directly irritates the airways and can provoke an attack. Whether an asthmatic is a smoker, or is frequently exposed to secondhand smoke, it's important to know how to manage smoke triggers effectively.

Help your patients quit smoking and manage their asthma by offering these resources available in our **Learning Center**.

- *Time to Quit* online program – complete a personalized quit plan.
- *Preparing to Quit Tobacco* – a recorded class that teaches skills to address addiction and offers tools to prepare to quit.
- *Basics of Asthma Management* online program – reviews asthma symptoms, triggers, proper medication use, self-care skills, and more.

When a patient reports having asthma symptoms, such as breathing issues when exposed to allergens or other triggers such as smoke, the spirometry test can be the most valuable and essential test in confirming the diagnosis of asthma. For more information on guidelines and the value of the spirometry test, visit www.choosingwisely.org.

References:

1 Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2017. Analysis performed by the American Lung Association Epidemiology and Statistics Unit using SPSS software. Located at: <https://www.lung.org/lung-health-diseases/lung-disease-lookup/asthma/asthma-symptoms-causes-risk-factors/smoking-with-asthma>

2 Asthma.com – Here for Every Breath, located at: https://www.asthma.com/understanding-asthma/asthma-triggers/asthma-and-smoking/?cc=ps_8P0M72MX447515508mcm=200000&gclid=c7142c33d33d15ba72a84c331efaf0d9&gclsrc=3p.ds





TRICARE Updates Regarding Lower Back Pain

As a reminder, TRICARE has put into effect the following policy updates related to the diagnosing and treatment of low back pain.

Low Back Pain Imaging: Retroactive to Oct. 30, 2020, TRICARE no longer covers diagnostic imaging for TRICARE beneficiaries with acute low back pain within six weeks of the onset of symptoms when no red flags are present. The five specific red flags are:

- Possible fracture
- Possible tumor, cancer or infection
- Possible cauda equina syndrome
- Major motor weakness
- Progressive neurological symptoms

It is important when submitting claims for LBP imaging to include appropriate, specific diagnosis codes indicating medical necessity, when required. Be sure to complete the following claim form fields:

- 'Date of current illness or injury' with qualifier 431 (professional claim form)
- 'Onset of current symptoms or illness' with occurrence code 01-05 or 11 and qualifier BH (institutional claim form)

Claims received without these fields may be denied.

Low Back Pain Physical Therapy Demo: On Jan. 1, 2021, DHA launched its Low Back Pain Physical Therapy Demonstration. This demonstration waives cost-sharing for up to three physical therapy (PT) visits for patients with low back pain (LBP) and is limited

to beneficiaries in 10 states, including the following states in the West region: Arizona, California and Colorado. The purpose of this demonstration is to evaluate whether waiving the cost sharing responsibility increases beneficiary participation in PT; decreases low-value care; and/or decreases the overall cost of care for treating patients with LBP.

- This demonstration applies to PT episodes of care that started on or after Jan. 1, 2021. TRICARE patients who were receiving PT services before Jan. 1 may not receive waived cost-shares for services received after the start of the demonstration.
- A TRICARE-authorized provider must refer beneficiaries to treatment.
- A network provider must provide the PT services. (Exception: TRICARE For Life beneficiaries may receive PT services from a non-network TRICARE-authorized provider.)
- There is no time limit between the onset of symptoms and receiving PT services under this demonstration.
- Visits for acute, subacute or chronic LBP may be eligible for this benefit.
- After the third, cost-share waived PT session, beneficiaries will be responsible for standard cost-shares for future sessions.

To learn more about these updates, visit our [Benefits A-Z](#).



Unit Limits for TENS Supplies

The Defense Health Agency and Health Net Federal Services, LLC (HNFS) have noticed an increase in claims for Healthcare Common Procedure Coding System (HCPCS) A4595 – electrical stimulator supplies (e.g., TENS) – with unit counts that far exceed the HCPCS manual description of one unit/two leads per month. As a result, and to allow for two- and four-lead TENS, we have updated our claims processing systems to impose a limit of two units/four leads per month for TENS supplies billed under A4595. This change went into effect on Feb. 17, 2021.

Currently, TRICARE policy does not specify a unit limit for A4595; however, contractors such as HNFS are given discretion to set limits where none exist, based on best business practices. For dates of service Feb. 17, 2021 and after, units in excess of two units/four leads per month for A4595 will not be reimbursed. Please make note of this when prescribing and billing for TENS supplies.

Find additional benefit details on our [Benefits A–Z](#) page.

DRG Reimbursement Updates

TRICARE recently introduced two updates pertaining to inpatient services paid under the Diagnosis-Related Group (DRG) reimbursement methodology. Find additional details on our [DRG Hospital Reimbursement](#) billing tips page.

Hospital Value-Based Purchasing Program

Effective for discharges on or after Jan. 1, 2020, and implemented on March 3, 2021, TRICARE adopted the Centers for Medicare and Medicaid Services' (CMS) Hospital Value-Based Purchasing (HVBP) Program for hospitals under the Inpatient Prospective Payment System (IPPS). The HVBP Program rewards acute care hospitals with incentive payments based on the quality of care they deliver. Hospitals subject to HVBP are reimbursed using adjustment factors found in the current CMS IPPS Final Rule Table, available at www.cms.gov/medicare/acute-inpatient-pps.

The HVBP program withholds participating hospitals' payments by a percentage specified by law and uses the payment reductions to fund value-based incentive payments to hospitals. A claim-by-claim adjustment factor is applied to the base operating DRG payment. The HVBP adjustment is added (if positive value) or subtracted (if negative value) from the TRICARE allowed amount in order to determine the final claims payment amount.

Hospitals, skilled nursing facilities and other institutional providers under the IPPS are subject to HVBP under TRICARE.

Hospitals excluded from IPPS are not subject to HVBP. These include psychiatric hospitals; rehabilitation hospitals; long-term care (LTC) hospitals; children's hospitals; critical access hospitals (CAHs); PPS-exempt TRICARE cancer hospitals, and state of Maryland hospitals.

New Technology Add-On Payments

New Technology Add-On Payments, or NTAPs, allow for more appropriate reimbursement for new medical services and technology not yet included in DRG rates. As of Feb. 9, 2021, TRICARE adopted the Centers for Medicare & Medicaid (CMS) NTAPs reimbursement methodology for new services/technology not yet in the DRG, under the hospital Inpatient Prospective Payment System (IPPS). TRICARE's adoption of NTAPs applies to hospital discharges on or after Jan. 1, 2020.

Find the current list of NTAPs and reimbursement rules at www.cms.gov. The reimbursement amounts in the IPPS Final Rule represent the maximum add-on payment for each NTAP. CMS updates maximum NTAP payment amounts annually.

For inpatient hospital claims, NTAPs may be applied when reimbursement is equal to the lesser of:

- 50% of the amount by which total covered costs exceed the Medicare Severity (MS)-DRG payment, or
- The maximum NTAP payment amount for the specific technology.

E/M Office Visit Code Update

In an effort to lessen the administrative burden for providers, the Centers for Medicare & Medicaid Services (CMS) implemented revisions to the Evaluation and Management (E/M) office visit CPT® codes (99201–99215). The American Medical Association (AMA) 2021 E/M updates include:

- Deletion of CPT® code 99201
- New guidelines specific to CPT® codes 99202–99215

Health Net Federal Services, LLC has updated our online authorization submission tools, CareAffiliate and the Web Authorization and Referral Form (WARF), to reflect these changes. For more information regarding this update, visit <https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>.

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Study: Greater Rx Adherence in Home Delivery Customers

According to a recent study¹ conducted by Express Scripts Pharmacy, patients who have their medications delivered to their homes have better adherence, fewer emergency room visits, and fewer hospitalizations than those who fill prescriptions at a retail pharmacy.

A closer look

The study is a retrospective analysis of pharmacy claims managed by Express Scripts Pharmacy in 2018 and 2019 for more than 1.75 million customers with employer-provided insurance. It focuses on those who use medications to treat diabetes, hypertension or high blood cholesterol – three of the most prevalent and costly conditions for payers.

The analysis compares adherence rates, emergency room visits and hospitalizations of customers who filled their prescriptions for these conditions via Express Scripts Pharmacy with those who filled their prescriptions at a retail pharmacy.



With resources like mobile applications, autofill programs, access to pharmacists 24 hours a day, 365 days a year, and consistent pharmacy processes, home delivery services such as Express Scripts Pharmacy can ensure your patients always have their medication on hand. This can help them remain adherent, and improve their health outcomes and overall plan spending.

Additional information

View the [entire study](#) safely more information.

References:

1 Rochelle Henderson, PhD. "Express Scripts Pharmacy Increases Adherence and Savings." Express Scripts. 18 December 2020. Retrieved from <https://www.express-scripts.com/corporate/index.php/articles/express-scripts-pharmacy-increases-adherence-and-savings>.

Suicide Prevention in the Primary Care Setting

Suicide is the tenth leading cause of death overall in the United States. Despite improvements in overall health and health care, the national suicide rate has risen about 27% in the last 15 years. Suicide rates have similarly increased due to COVID-19 related shutdowns, anxiety and stressors related to job and financial losses, and social isolation. Almost one-half of patients who died by suicide visited a primary care provider in the month before their death¹. These statistics present an opportunity for health care providers to improve current standards of care to identify the risk of suicide.

The National Action Alliance for Suicide Prevention² recommended standards of care for people with suicide risk to include:

- **Safety Planning:** A brief intervention to help patients develop a plan to recognize suicidal thoughts and manage them safely. Action steps may include calming activities, identifying supportive people to talk with, and providing contact information for crisis calls or text lines. Crises call centers that are part of the National Suicide Prevention Lifeline also make caring contacts.
- **Lethal Means Reduction:** Identifying possible means of self-harm that are available to the individual, such as weapons or prescription medications, and taking steps to remove them from access. You can help educate families about how to reduce lethal means and confirm comprehension of the message. Find online training modules on both safety planning and lethal means reduction at www.zerosuicide.com.

The Action Alliance created a framework for recommended standards of care for people with suicide risk in every patient care setting (<https://theactionalliance.org/>). Applications in the primary care setting include:

1. Identify suicide risk among patients diagnosed with mental illness/substance use disorder conditions to enhance safety for those with potential risk. Refer patients to inpatient or outpatient care, as appropriate, if risks are identified.
2. Refer patient to specialized care and provide caring contacts.
3. Safety planning should include a brief safety planning intervention during the visit when risk is identified.
4. With consent, discuss a safety plan with the family to gain support.
5. Discuss any lethal means considered by and available to patients. Take steps to reduce patient access to lethal means by asking family members and significant others to assist. Arrange and confirm removal or reduction of lethal means as feasible.
6. Encourage at-risk patients to make an appointment with a mental health professional. Complete one contact (phone call or, if preferred by patient text or email) within 48 hours of the primary care visit or the next business day.
7. Provide information on telephone crisis lines, including the National Suicide Prevention Lifeline.

References:

1 Luoma, J.B., Martin, C.E. & Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *The American Journal of Psychiatry*, 159(6), 999-916.

2 National Action Alliance for Suicide Prevention. <https://theactionalliance.org/>



Let Your Patients Know About Telehealth Options

TRICARE continues to waive copayments and cost-shares for covered telemedicine services. This waiver applies to covered in-network telehealth services, not just services related to COVID-19. Referral requirements for covered telemedicine services are the same as those for in-person visits.

Directory listing

Do you offer telehealth services? If you are not already listed as a telemedicine provider in our directory, submit a [TRICARE Provider Group Roster](#) to let us know which providers in your practice offer video telemedicine services. If you use a different template, please indicate on it who offers telemedicine services.

While TRICARE is temporarily allowing for audio-only telehealth in response to COVID-19, directory search results will only include providers who have notified HNFS they offer video telemedicine services.

Additional telehealth options

TRICARE West Region beneficiaries can also access telemedicine support through Telemynd and Doctor on Demand. Visit our [Network Provider Directory](#) page to learn more.

TRICARE's Right of First Refusal

As a TRICARE requirement, when a TRICARE Prime beneficiary is referred for specialty care, HNFS will first attempt to coordinate care at a military hospital or clinic, even if the beneficiary is enrolled to a civilian primary care manager. This process is known as TRICARE's right of first refusal. Providers should include as much clinical documentation or details as possible when submitting referrals to HNFS in order for the military hospital or clinic to reasonably determine if they have the ability to effectively treat the beneficiary.

Be sure to review the details of determination letters issued by HNFS with your TRICARE patients. Each determination letter issued by HNFS will specify the approved specialty provider. If a beneficiary sees a different specialty provider, Point of Service charges may apply.



Submitting Patient Encounter Reports to Referring Military Providers

Are you treating a TRICARE patient who was referred by a military hospital or clinic? One requirement of TRICARE network providers is to submit patient encounter reports – also known as clear and legible reports or CLRs – to referring military hospitals or clinics within specified time frames. The requirement to submit CLRs applies to care referred by a military hospital or clinic, and to care received at an urgent care center.*

Why send CLRs?

- They help expedite treatment and ensure continuity of care for your TRICARE patients.
- They meet The Joint Commission standards.

A Health Net Federal Services, LLC representative will reach out to offer education and assistance to providers who fail to submit required CLRs.

Find CLR submission details, including submittal time frames and our CLR Fax Matrix on our [Patient Encounter Reports](#) page.

* Network urgent care centers should submit CLRs to the beneficiary's assigned military hospital or clinic, as there may not be a referring provider.

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CONTACTS

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Pharmacy inquiries
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www.express-scripts.com/TRICARE

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