TRICARE®

Provider NEWS

April 2022

ISSUE HIGHLIGHTS

COVID-19 Updates

TRICARE continues to follow Centers for Disease Control and Prevention (CDC) guidelines on COVID-19 testing, treatment and vaccines. In this ever-changing environment, be sure to visit www.cdc.gov, www.tricare-west.com and www.tricare.mil for up-to-date information. Recent updates include:

- **At-home tests –** TRICARE covers **medically necessary COVID-19 tests** ordered by a TRICARE-authorized provider and performed at a TRICARE-authorized lab or facility. FDA-approved at-home antigen rapid diagnostic test kits may be covered with a physician's order.

  Free at-home antigen rapid diagnostic tests available outside the TRICARE benefit include those ordered from **https://www.covidtests.gov**, distributed by local military hospital or clinics (supply is limited and may vary), and covered by another health plan.

  Reminder: The current mandate for private insurance companies to cover FDA-approved at-home COVID-19 tests without a physician's order does not apply to TRICARE. Currently, TRICARE requires medical necessity and a physician's order.

- **Oral antiviral treatment –** The U.S. Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for Paxlovid® and Molnupiravir® for the treatment of mild-to-moderate COVID-19. Paxlovid and Molnupiravir oral antiviral treatments may be prescribed to those who have tested positive. The FDA recommends Paxlovid as a first-line treatment; Molnupiravir is used as a last resort due to relatively lower efficacy and some exclusions for use in pregnancy. Beneficiaries can fill prescriptions for these treatments at network, non-network or military pharmacies, ***subject to availability.***

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Orders, Referrals and Authorizations: What's the Difference?

Referral and authorization requirements for your TRICARE patients vary based on plan type. Health Net Federal Services, LLC (HNFS) has noticed an increase in beneficiaries receiving paper orders for care without a referral submission to HNFS. We've also seen instances of referral or authorization requests submitted for care that only needed a provider's order. Understanding when and when not to request a referral or authorization can help expedite your patients' access to care.

Provider orders

Ancillary services, also referred to as diagnostic services, allow providers to assess patients and determine appropriate treatment. Examples include laboratory and radiology tests, echocardiograms, Holter monitors, and routine treadmill tests. Most ancillary services do not require a separate approval from HNFS, and a provider's order is sufficient. *Not sure?* Search our **TRICARE Ancillary Services** list for approval requirements.

Please note: For patients enrolled in TRICARE Prime, orders must be from their primary care manager (PCM) or specialist they were approved by HNFS to see.

Referrals

Referrals are for services not considered primary care. For example, when a PCM sends a patient to see a cardiologist to evaluate a possible heart problem. Beneficiaries enrolled in a TRICARE Prime plan require a PCM referral for most, but not all, specialty care. Use our **Prior Authorization, Referral and Benefit Tool** to check requirements ***before*** submitting anything to HNFS.

Authorizations

Authorizations are for certain services and/or procedures that require HNFS review and approval prior to being provided. Using the referral example above, if the cardiologist determined surgery was needed, an authorization would be required for that surgery. As with referrals, you should also use our **Prior Authorization, Referral and Benefit Tool** to check requirements ***before*** submitting requests to HNFS.

Learn more about **authorization and referral submissions** on our website.

Did you know? While HNFS processes most routine authorization and referral requests within two business days, it can take us up to five business days to complete processing. Please allow us the full five days before calling to check status. Don't forget! You can log in at **www.tricare-west.com** or use the self-service prompts through our customer service line to easily check status 24/7.

Using CareAffiliate® for Authorization and Referral Requests

With the exception of providers in Alaska, TRICARE West Region providers must submit all authorization and referral requests online. The preferred method for online submissions continues to be **CareAffiliate®**, which can be used for inpatient and outpatient requests, and allows for attachments. If you are not yet registered to use our secure tools, get started by clicking "Register" at the top of the provider portal at **www.tricare-west.com**.

Checking Patient Eligibility Using Self-Service Tools

Verifying your patients' TRICARE eligibility details is an important step prior to rendering care. We offer three self-service options to help streamline the eligibility verification process.

1. Log in at **www.tricare-west.com** and click on "Eligibility & Deductible" from the Secure Tools box. Be sure to retain a printout of the eligibility verification screen for your files.
2. Use the self-service prompt when calling 1-844-866-WEST (1-844-866-9378).
3. Submit an electronic data interchange transaction.

Benefit Corner

Extended Care Health Option Respite Care Update

To provide a break for primary caregivers, beneficiaries eligible for Extended Care Health Option (ECHO) benefits also have access to a maximum of 16 hours of respite care per month. Retroactive to Aug. 9, 2021, TRICARE removed the prerequisite requiring beneficiaries registered in ECHO to receive other authorized non-respite care during the same month. Previously, ECHO respite care was only allowed within the same month that a separate ECHO benefit was authorized and given.

ECHO provides additional services and supplies that are not available through the basic TRICARE program. Visit our **ECHO Benefits** page for more information on what is covered.

Childbirth and Breastfeeding Support Demonstration

As of Jan. 1, 2022, TRICARE allows for certified labor doulas, lactation consultants, and lactation counselors – previously excluded as TRICARE-authorized provider types – to provide reimbursable care to TRICARE beneficiaries under its Childbirth and Breastfeeding Support Demonstration. Labor doulas, lactation consultants and lactation counselors must meet the certification requirements outlined in the TRICARE Operations Manual, Chapter 18, Section 11 in order to be reimbursed under the demonstration.

Beginning in April 2022, contractor provider directories will reflect the provider types allowed under the demonstration.

Interested in joining our network?

Providers interested in joining the TRICARE West Region network may contact us for additional information (additional network requirements apply). Existing network groups who have these provider types should notify us via an updated roster. Non-network applications are available on our **Non-Network Certification Applications** page.

Find additional details about TRICARE's Childbirth and Breastfeeding Demonstration on our **Maternity Care** benefit page.

Podiatry: Non-Invasive Vascular Testing

As of Dec. 27, 2021, TRICARE allows for reimbursement to podiatrists who perform noninvasive vascular diagnostic testing in conjunction with podiatry services. Previously, such services were excluded. Affected testing includes cerebrovascular arterial studies, extremity arterial studies (including digits), extremity venous studies (including digits), and extremity arterial-venous studies. The Current Procedural Technology (CPT®) code range for these procedures is 93875 through 93990.

The podiatrist's state license must allow for such testing.

Please refer to TRICARE Policy Manual, Chapter 7, Section 12.1 and our **Vascular Diagnostic Studies** benefit page for more information.

Multiple Prosthetics

Prosthetics, also known as prosthesis and related supplies, are covered under TRICARE when medically necessary. Prior policy specified that only one prosthetic may be covered at a time unless the beneficiary required bilateral prosthetics. Recent updates to the TRICARE Policy Manual (Chapter 8, Section 4.1) clarify that while in most cases only one permanent prosthetic at a time is medically necessary, additional prosthetics may be covered if they serve a different purpose or have essential functional differences, even if used for the same limb.

Visit our **Prosthetics** benefit page to learn more about coverage and prior authorization requirements.

Autism Care Demonstration Updates

Annual Provider Training

If you are an autism corporate services provider (ACSP) or applied behavior analysis (ABA) sole provider participating in the Autism Care Demonstration (ACD), you should have received your training assignment notification via email. All ACSPs and ABA providers must complete the annual training, which is available on demand 24/7. Once assigned, you have 90 days to complete the training. Providers who miss the 90-day deadline are subject to a 10% penalty. This penalty will be applied to all claims beginning on day 91 until the training is complete.

Claims Audits

Health Net Federal Services (HNFS) reviews provider billing practices to verify services ABA providers bill TRICARE for are approved under the ACD and supported by clear and complete progress notes or medical documentation. Repeated audit failures may result in provider education or other more severe action.

ACSPs and sole ABA providers are subject to a minimum of 30 record reviews annually. These include administrative and medical documentation reviews, and a review of one medical team conference progress note, if available. Separately and on an ongoing basis, HNFS reviews Current Procedural Terminology (CPT®) code billing practices to ensure compliance with TRICARE requirements.

We want to help you be successful prior to your audit. We offer keys to success and detailed information on our **ACD: Compliance and Audit** page.

Choosing Wisely®

Exercise-Induced Bronchoconstriction

Exercise-induced bronchoconstriction (EIB) is a common problem in physically active people. EIB is defined as transient, reversible bronchoconstriction that happens during or after strenuous exercise and can occur in those with or without underlying asthma. More than 10% of the general population, and up to 90% of those diagnosed with asthma, have EIB. Athletes who participate in endurance and cold-weather sports tend to be at increased risk.

Common symptoms of EIB:

- coughing
- wheezing
- chest tightness with exercise
- fatigue
- impaired athletic performance

For patients who have not previously been diagnosed with asthma, a spirometry test can help evaluate for underlying chronic asthma. A trial of short-acting medications to relax muscles of the airways or additional bronchial provocation testing may be necessary to confirm the diagnosis. Visit **Choosing Wisely** for additional guidance on spirometry and other asthma-related procedures. Visit the **American Family Physician Journal** for more information on diagnosing EIB for patients without a previous diagnosis of asthma.

People who have EIB may still be able to exercise; however, they may need to avoid certain activities. Best options include moderate exercise like walking, biking, golf, indoor sports, and activities performed in a warm, humid environment. Medicine can prevent and manage most symptoms, but lifestyle choices can help too. Patients should warm up before and cool down after exercise; avoid exercising in very cold temperatures, when sick with a cold or flu, and when their allergies are bad; and stop smoking if they smoke.

HNFS offers the following resources for your patients.

1. **The Basics for Asthma Management** online program
2. **Fitness for Life** – Module 5 in the Healthy Weighs for Life online program
3. **One-on-one coaching** with an asthma specialist for patients diagnosed with asthma

References:

Randolph C. An update on exercise-induced bronchoconstriction with and without asthma. *Curr Allergy Asthma Rep*. 2009;9(6):433–438.

MICHAEL A. KRAFCZYK, MD. Exercise-induced bronchoconstriction: Diagnosis and Management at https://www.aafp.org/afp/2011/0815/p427.html. *Am Fam Physician.* 2011 Aug 15;84(4):427-434.

Section 4, Managing asthma long term—special situations. In: National Heart, Lung, and Blood Institute, National Asthma Education and Prevention Program. Located at: https://www.ncbi.nlm.nih.gov/books/NBK7226/. Updated 2020 Asthma Care Quick Reference, Diagnosing and Managing Asthma. Located at: https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf, page 4.

National Heart, Lung, and Blood Institute, 2020 Focused Updates to the Asthma Management Guidelines. Located at: https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/2020-focused-updates-asthma-management-guidelines.

Understanding Acute Low Back Pain

Low back pain is one of the most frequent physical complaints by patients. According to the European Journal of Physical and Rehabilitation Medicine, it's estimated five out of six Americans will be affected by low back pain at some point during their lifetime. Compared to chronic low back pain, which can persist for several months and may recur, acute low back pain usually lasts no longer than six weeks and resolves without intervention.

While many acute low back pain cases may not have a definite cause, common causes include:

- intense physical exertion
- obesity
- normal aging

If necessary, treatment is generally short term and encompasses noninvasive care such as:

- Medications, including nonsteroidal anti-inflammatory drugs (NSAIDS), acetaminophen and muscle relaxants.
  Note: Long-term use of medications is discouraged for chronic low back pain.[1]
- Continued activity, as bedrest may result in mobility complications.
- Physical therapy and low-intensity exercise to relieve muscle aches and build muscle strength (see Low Back Pain Physical Therapy Demonstration article).
- Patient education.

Patients with acute low back pain who present with other neurological symptoms, such as urinary incontinence or lower limb paralysis, should receive immediate medical care to determine the underlying condition.[2]

References

1Casazza, B. (2012). Diagnosis and treatment of acute low back pain. American Family Physician, 85(4), 343-350. Retrieved September 3, 2021, from American Family Physician: https://pubmed.ncbi.nlm.nih.gov/22335313/

2Traeger, A., Qaseem, A., & McAuley, J. (2021). Low back pain. JAMA, 326(3), 286. doi:10.1001/jama.2020.19715

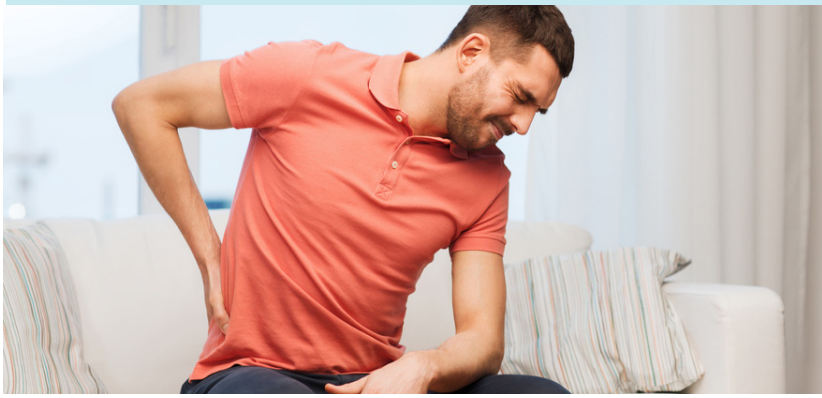
Low Back Pain Physical Therapy Demonstration

For your patients with low back pain, we want to remind you about TRICARE's Low Back Pain Physical Therapy Demonstration. Last year the Defense Health Agency authorized this demonstration, which waives cost-sharing for up to three physical therapy (PT) visits for patients with low back pain. After the three visits, the beneficiary is responsible for their regular cost-shares and copayments for future visits. In the TRICARE West Region, this demonstration is currently only available in Arizona, California and Colorado.

Low Back Pain PT Demonstration requirements:

- Applies to new PT episodes of care on or after Jan. 1, 2021.
- Care must be referred by a TRICARE-authorized provider.
- Care must be rendered by a network provider. (Exception: TRICARE For Life beneficiaries may receive care from any TRICARE-authorized PT provider.)

Visit our **Physical Therapy** benefit page for more information.



TRICARE's Right of First Refusal

When a TRICARE Prime beneficiary is referred for specialty care, TRICARE requires Health Net Federal Services (HNFS) to 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 as many details as possible when submitting referrals to HNFS, as this will help military hospitals and clinics 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 provider other than who was approved, point-of-service charges may apply.

Improving Patient Health and Satisfaction with Real-Time Prescription Benefit

In the fast-paced world of health care, it is necessary for providers to have actionable patient-specific data available.

Express Scripts delivers real-time, patient-specific pharmacy data on TRICARE beneficiaries to providers who have the Real-Time Prescription Benefit functionality integrated within their electronic health record (EHR). Providers can see a holistic view of their TRICARE patients' profiles and the best prescribing options for them.

The Real-Time Prescription Benefit functionality gives you access to:

- TRICARE patient out-of-pocket costs
- Coverage alerts
- Therapeutic alternatives
- Pharmacy choices
- Prior authorization requirements

Within seconds, you will have access to patient-specific information and pricing, helping you to prescribe the right medication for your patient, knowing if it will be covered under their TRICARE pharmacy benefit. Patients will gain confidence in their medication therapy and the costs associated with it. Providers benefit by reducing wait times and getting medicine to patients more efficiently.

For providers without EHR access, Express Scripts offers the ScriptVision℠ Physician mobile app, where physicians can quickly access their patients' pharmacy benefit information, directly on their iOS mobile device. Providers can download and register with the app using their iPhone® or iPad® to get started.

To learn more about Real-Time Prescription Benefit functionality visit, **www.militaryrx.express-scripts.com**.

Are You Submitting Patient Encounter Reports to Referring Military Providers?

If you 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 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.*