The Jan. 1–Dec. 31, 2020 TRICARE West Region Provider Handbook will be available to preview online on Dec. 1, 2019, at www.tricare-west.com > Provider > Resources > Handbook, Manuals & Charts. This handbook is updated annually, and contains important information regarding the TRICARE program. Please review the handbook in its entirety, as it is a component of the Health Net Federal Services, LLC (HNFS) West Region Network Provider Participation Agreement.

Changes to TRICARE programs are continually made as public law, federal regulation, and HNFS’ managed care support contract are amended. Continue to visit www.tricare-west.com for the most up-to-date information.

Online Education for Providers

HNFS’ online education options include live TRICARE webinars hosted by one of our TRICARE representatives, videos and printable PowerPoint presentations, all viewable from the comfort of your home or office. Understanding the basic TRICARE requirements can assist you when working to achieve the best possible health outcomes for your TRICARE patients.

Looking for continuing education credit? The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) offers a free monthly webinar series focusing on active duty military, their beneficiaries and veterans’ psychological health and traumatic brain injury. Learn about the newest medical research and receive continuing education credit.

Find the complete online education schedule at www.tricare-west.com > Provider > Education/TRICARE Webinars.
Referring Patients for Specialty Care

Referrals are for services that are not considered primary care. For patients enrolled in TRICARE Prime (an HMO-type plan), most referrals must be approved by HNFS. Without this approval, treatment from specialty care providers may be subject to point-of-service charges. Save time and help your patients avoid unexpected out-of-pocket costs – learn the before, during and after steps of the TRICARE referral process.

What do I do before I submit a referral for HNFS approval?

1. Check referral requirements at www.tricare-west.com > Providers > Authorizations > Is Approval Needed? We also list referral requirements on many of our Benefits A–Z pages.

2. Verify if the service is an ancillary service, such as diagnostic radiology or laboratory tests. Most ancillary services do not require HNFS approval. Go to www.tricare-west.com > Providers > Authorizations > How Do I … Review Approval Requirements for Ancillary Services.

How do I submit referrals?

Log in at www.tricare-west.com to use CareAffiliate®. If you do not yet have a web account and are requesting outpatient specialty care, you can use our Web Authorization/Referral Form (WARF).

What are request types?

Request types are referral (and authorization) templates created by HNFS. Each request type has specified codes/code ranges that will pre-populate in your request once selected.

Find this list of request types in the step-by-step CareAffiliate and WARF guides at www.tricare-west.com > Provider > Authorizations > Submit a Request.

Outpatient Specialty Referral Request Types

<table>
<thead>
<tr>
<th>Description</th>
<th>Included CPT® Code(s)</th>
<th>Request Type</th>
<th>Approval Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate and Treat Specialty Referral</td>
<td>99201–99205, 99211–99215, 99241–99245</td>
<td>P1</td>
<td>180 days for ADSMs 365 days for non-ADSMs</td>
</tr>
<tr>
<td>Evaluate Only Specialty Referral</td>
<td>99201–99205, 99211–99215, 99241–99245</td>
<td>P3</td>
<td>180 days</td>
</tr>
<tr>
<td>Oncology – Evaluate and Treat Spec Ref</td>
<td>99201–99205, 99211–99215, 99241–99245</td>
<td>P6</td>
<td>365 days</td>
</tr>
<tr>
<td>Pre/Post Transplant</td>
<td>99211–99215, 99241–99245</td>
<td>P58</td>
<td>360 days for codes 99211–99215 90 days for codes 99241–99245</td>
</tr>
<tr>
<td>Routine Eye Examination</td>
<td>92002–92015</td>
<td>P63</td>
<td>90 days</td>
</tr>
<tr>
<td>Second Opinion</td>
<td>99201–99205, 99211–99215, 99241–99245</td>
<td>P5</td>
<td>90 days</td>
</tr>
<tr>
<td>Specialty Referral Extension</td>
<td>99211–99215</td>
<td>P4</td>
<td>180 days, dependent on initial episode of care date</td>
</tr>
</tbody>
</table>

ADSMs = active duty service members
Request types, descriptions and corresponding codes are subject to change.

How do I know if I need an “Evaluate and Treat Specialty Referral” or an “Evaluate Only Specialty Referral”?

Evaluate-only referrals allow the beneficiary two office visits with the specialist to evaluate and diagnose, but not treat. Most ancillary services (such as lab, X-ray) may be provided, but subsequent care beyond two visits or treatment will require a new approval.

Evaluate and treat referrals allow for one evaluation visit and five follow-up visits with the specialist. Most ancillary services and subsequent careRELATED procedures during the five follow-up visits may be provided without a separate approval.

What do I do after the referral has been submitted?

Allow HNFS 2–3 business days to process routine requests. Requests for urgent care needed within 72 hours are processed in an expedited manner. Remember, HNFS will always attempt to coordinate care at a military clinic or hospital first. The process is known as the right of first refusal, which is explained in detail on page 3.

How do I check the status of my request?

Log in at www.tricare-west.com to check status. Once processed, HNFS will fax a determination letter to the specialist and the referring provider. Beneficiaries may log in at www.tricare-west.com to view a copy of the determination letter. Remind your patients not to schedule specialty appointments until the referral has been approved, and to always verify whether care has been re-directed to the local military hospital or clinic.

For more information on the complete referral process, HNFS offers an outpatient referral flow chart at www.tricare-west.com > Providers > Education > Quick Reference Charts > Life of an Outpatient Referral.
TRICARE’s® Right of First Refusal

Per TRICARE requirements, 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. Local military hospitals or clinics will first determine if they can provide the services. If they cannot, HNFS will coordinate the care with a TRICARE network provider. (In limited circumstances, a TRICARE Prime beneficiary may see a non-network provider if there are no network providers available.) When submitting a referral to HNFS, include as much clinical documentation or details as possible. This will allow the military hospital or clinic to reasonably determine if it has the ability to effectively treat the beneficiary.

Review the details of determination letters issued by HNFS with your TRICARE patients. Each determination letter will specify the approved specialty provider. If a beneficiary sees a provider other than the one indicated on the letter, point-of-service charges may apply. A review of TRICARE referral basics can be found online at www.tricare-west.com > Provider > Authorizations.

Claim Denials

**Appeal or Request a Review?**

If a TRICARE claim denies, before submitting an appeal to HNFS, take a moment to review the differences between appeals and claim reviews. Often, a claim review can resolve the issue. Find detailed information on claim appeals at www.tricare-west.com > Provider > Claims > Appeals.

**Appeals**

**What types of claim denials can be appealed?**

Claims may only be appealed if the charges were denied due to the service not being covered by TRICARE or not medically necessary. This includes point-of-service charges for emergency care. The denial note on the Explanation of Benefits (EOB) will indicate whether or not the denial is appealable.

**Who can submit a claim appeal?**

- The TRICARE beneficiary (or parent of a minor)
- A non-network provider if he or she accepted assignment on the claim, and he or she performed the services
- A network provider if appealing a claim on his/her own behalf and the denied claim is appealable per the remittance notice (Network providers cannot bill patients for non-covered services or services denied as not medically necessary.)
- An attorney
- A legal guardian of the beneficiary
- A representative, as designated on an Appointment of Representative Form (available on our Forms page)

**What are non-appealable issues?**

Common non-appealable issues include: underpayment disputes, corrected claims, third party liability claims, and lack of other health insurance information. *(This list is not all-inclusive.)*

**What should be included with an appeal request?**

- An explanation of what is being appealed
- The sponsor’s Social Security number, claim/authorization number(s), date(s) of service (when applicable), name of the beneficiary and the beneficiary’s date of birth
- The provider’s remittance notice, EOB or the determination/denial letter
- Supporting medical records

**How do I submit an appeal?**

In an effort to safeguard beneficiary personal health information (PHI), appeals must be sent to the appropriate department for proper processing and handling.

- HNFS can accept claim appeals one of three ways: online, via fax or via postal mail. Find submission details at www.tricare-west.com > Provider > Claims > Appeals.
- Claim appeals must be submitted within 90 calendar days of the date on the EOB or provider remit.
- Do not submit claim appeals to PGBA, LLC, HNFS’ claims processing partner, as they are unable to process these requests.
- HNFS responds to claim appeal requests within 30 days of receipt.

**Claim Reviews**

Claim reviews may be requested for concerns about how a claim was processed, rather than charges denying as not covered or not medically necessary. Claim reviews must be submitted in writing within 90 calendar days of the date on the EOB or provider remit. Please include a copy of the claim, EOB, any supporting medical records, and any new information not previously submitted with the claim. HNFS responds to claim review requests within 30 days of receipt.

View detailed claim review instructions at www.tricare-west.com > Provider > Claims > How Do I … Request a Claim Review.
Claims Tips

Modifiers for Unlisted Codes on Breast Pump Supply Claims

Expecting mothers can access TRICARE’s breast pump and breast pump supply benefit starting at week 27 of pregnancy (or when the baby is born, if premature) or in the instance of adoption. One breast pump kit is covered per birth event but may not be reimbursed separately from the initial breast pump. Replacement supplies may be covered, but are limited per TRICARE policy. A prescription is required for the supplemental nursing system and two sets of nipple shields, and when billing in excess of the below breast supply limits. HNFS offers a Breast Pump and Supplies Prescription Form you can submit with your claim in lieu of a certificate of medical necessity for excess supplies.

In order for HNFS to accurately reimburse providers who bill for breast pump supplies using unlisted Healthcare Common Procedure Coding System (HCPCS) codes A9900 or A9999, we are requesting providers use the following modifiers. These modifiers will let us know specifically which supplies were provided to the beneficiary.

<table>
<thead>
<tr>
<th>Supply Type</th>
<th>Modifier</th>
<th>Quantity Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replacement valves/membranes</td>
<td>XG</td>
<td>12 every 12 months (1 unit = a set of 2 valves/membranes)</td>
</tr>
<tr>
<td>Replacement breast milk storage bags</td>
<td>XH</td>
<td>90 individual bags every 30 days</td>
</tr>
<tr>
<td>Replacement nipple shields</td>
<td>XD</td>
<td>2 sets (2 shields/set) every birthing event</td>
</tr>
<tr>
<td>Supplemental nursing system</td>
<td>XN</td>
<td>1 every birthing event</td>
</tr>
<tr>
<td>Breast pump kit</td>
<td>XR</td>
<td>1 every birthing event (may not be reimbursed separately)</td>
</tr>
</tbody>
</table>


Banked Donor Milk Billing Tips

Banked donor milk is a covered benefit for infants who are critically ill and the mother’s milk is not available or isn’t enough. A total of 35 ounces per infant per day is covered for up to 12 months of age. Visit www.tricare-west.com > Provider > Benefits & Copays > Benefits A–Z > Milk (Banked Donor) for detailed information.

Banked donor milk billing tips and reminders:

- Providers must submit date ranges on the claim if requesting more than 35 ounces.
- Dates on prescriptions should not exceed the 30 day limit; a new prescription is required every 30 days.
- The amount and frequency of feedings should be notated on the prescription.
- The prescribing provider must be actively managing the infant’s care.
- Milk quantities should be in ounces only. For example, a claim with 100 mL will deny because our automated claims system reads it as 100 oz, which exceeds the daily 35 ounce limit.
Benefit Corner

Respite Care Basics

Respite care provides needed rest and time off for primary caregivers who care for patients at home. It is a limited TRICARE benefit available only to:

- The primary caregivers of active duty, Guard and Reserve service members who have been injured in the line of duty
- The primary caregivers of eligible TRICARE beneficiaries who are terminally ill and receiving hospice services

Line of duty

The line of duty respite benefit allows for a maximum of eight hours per calendar day, five days per calendar week, and prior authorization is required. To qualify, the service member must have a serious injury that has resulted in or may result in a physical disability or an extraordinary physical or psychological condition.

Hospice

Inpatient respite care in a hospice setting is limited to no more than five consecutive days at a time. Prior authorization for the hospice care is required. The necessity and frequency of the respite care will be determined by the hospice’s interdisciplinary group with input from the patient’s attending physician and the hospice’s medical director.

Extended Care Health Option and respite care

Beneficiaries eligible for the Extended Care Health Option (ECHO) also have access to respite care coverage. The ECHO Home Health Care respite benefit mirrors TRICARE coverage; however, it is limited to when the caregiver is sleeping and applies only to active duty family members at a maximum of eight hours per day, five days per week. ECHO respite care allows for a maximum of 16 hours of care within the same month that another ECHO benefit is authorized and given. For information on ECHO respite care, visit www.tricare-west.com > Provider > Resources > Wellness > Care Management > Extended Care Health Option (ECHO) > Benefits.

Portable CPAPs for Active Duty

Beneficiaries diagnosed with obstructive sleep apnea (OSA) syndrome or respiratory insufficiency may qualify to receive a Continuous Positive Airway Pressure (CPAP) machine under TRICARE’s durable medical equipment benefit. CPAP machines are a limited benefit and prior authorization is required.

Under the Supplemental Health Care Program, active duty service members can now be authorized to receive a portable CPAP device if they meet the following criteria and this criteria is documented on the authorization request:

- The active duty service member has a diagnosis of OSA; and
- The active duty service member travels on official business at least three days/month or is being deployed.

Portable CPAP devices must have humidification and battery capability.

If the service member already has a standard CPAP device, a portable device may be authorized if the criteria are met.

For additional benefit details, please visit www.tricare-west.com > Provider > Benefits A–Z > Continuous Positive Airway Pressure (CPAP) Machine.

Pediatric Hospice Care

TRICARE’s revised hospice benefit now includes concurrent hospice services and curative care for the same condition for beneficiaries under age 21. As directed by Congress, this aligns TRICARE with Medicaid’s model, and can help improve the quality of life for younger patients who suffer from life-threatening conditions.

In order to qualify for concurrent hospice and curative care, beneficiaries must:

- Be under age 21, with a life expectancy of six months or less if the terminal illness has run its normal course.
- Meet hospice eligibility and admission criteria.
- Have a referral to a participating hospice from an authorized provider.
- Have a signed and dated certification/attestation of terminal illness from the referring provider and the hospice medical director.

All hospice care requires HNFS approval. Approval requirements for curative care for beneficiaries under the age of 21 who have elected hospice vary by TRICARE plan type.

For additional benefit details, please visit www.tricare-west.com > Provider > Benefits A–Z > Hospice.

Psychological Testing Limits

Psychological testing is a covered TRICARE benefit when medically or psychologically necessary, and is provided in conjunction with otherwise covered psychotherapy or required applied behavior analysis assessments.

The Defense Health Agency limits TRICARE coverage for Common Procedural Terminology CPT® code 96137 to no more than 11 units per day (one unit equals one 30-minute increment). View the “Maximum Numbers of Services Per Day for Procedure Codes” list at https://health.mil > Military Health Topics > Business Support > Rates and Reimbursement > Limits on Number of Services without Override Code.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>96136</td>
<td>Psychological or neuropsychological test administration and scoring by qualified health care professional, first 30 minutes</td>
<td>1 unit</td>
</tr>
<tr>
<td>96137</td>
<td>Psychological or neuropsychological test administration and scoring by qualified health care professional, additional 30 minutes</td>
<td>11 units</td>
</tr>
</tbody>
</table>

Active duty service members require prior approval from HNFS. All other beneficiaries do not require HNFS approval; however, TRICARE Prime beneficiaries who seek care from non-network providers without HNFS approval are subject to point-of-service costs.

For additional information on the psychological testing benefit, visit www.tricare-west.com > Provider > Benefits and Copays > Benefits A–Z > Psychological Testing.

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Diabetes Prevention and Control Awareness

November is American Diabetes Month, an annual health campaign established to increase awareness of diabetes prevention and control.

- The rate of diabetes continues to increase in the U.S. and throughout the world.
- Diabetes may lower life expectancy up to 15 years and increase the risk of heart disease by two to four times.¹
- Diabetes is the leading cause of kidney failure, lower limb amputations and adult-onset blindness.²
- An estimated 86 million American adults have prediabetes, 70 percent of whom will ultimately develop type 2 diabetes. The U.S. Preventive Services Task Force recently recommended screening for prediabetes and diabetes, with subsequent referral to intensive lifestyle intervention (ILI) that promotes a healthful diet and physical activity for those who screen positive.³

As a health care provider who has direct influence on patients, you can support diabetes objectives through identifying patients who have increased risk of getting diabetes early, and providing education and encouragement to patients who have diabetes regarding proper self-management, timely screenings, and a healthy lifestyle. Primary care represents an important venue for addressing diabetes prevention, given that greater than 350 million adult ambulatory care visits are made annually, and screening tests including the annual HbA1c screening are commonly performed in this setting.

If you would like to nominate a beneficiary for the Case or Disease Management Program go to www.tricare-west.com > Provider > Secure Tools > Nominate a Beneficiary for Case or Disease Management. There is also a fax form available at www.tricare-west.com > Provider > Resources > Forms > Medical Management Nomination Form.


Clear and Legible Reports

What You Need to Know

TRICARE network providers are required to submit clear and legible reports – which includes consultation reports, operative reports and discharge summaries – to the referring* military hospital or clinic within specified timeframes.

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

Why send CLRs?

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

The requirement to submit CLRs applies to care referred by a military hospital or clinic, and to care received at an urgent care center.

Submittal time frames

- Most CLRs must be submitted within seven (7) business days of delivering care.
- Urgent care centers must submit within two (2) business days.
- Urgent and emergency situations, a preliminary report must be submitted within 24 hours of the urgent or emergent care.
- Mental health providers are required to submit brief initial assessments to the referring military hospital or clinic within seven (7) business days.

HNFS offers an online CLR Fax Matrix that lists military hospital or clinic secure CLR fax numbers and mailing addresses. To access the CLR Fax Matrix and for detailed instructions on submitting CLRs, visit www.tricare-west.com > Provider > Take Me To … Clear and Legible Reports.
Vitamin D Screening: Often an Unnecessary and Expensive Test

Vitamin D deficiency is common in patients who live at higher latitudes, during winter months and in those with limited sun exposure. Over-the-counter vitamin D supplements, increased summer sun exposure, and healthy lifestyle changes are sufficient for most otherwise healthy patients—without the need and unnecessary expense of screening for vitamin D deficiency. The American Society for Clinical Pathology in Choosing Wisely® recommends **not** performing population-based screening for 25-OH-vitamin D deficiency. Rather, screening should be reserved for higher risk patients in specific populations.

Laboratory testing is appropriate only in higher risk patients (such as those with osteoporosis, chronic kidney disease, malabsorption syndromes, some infections, and obesity), in which case the results direct more aggressive therapy.²

The vitamin D test is now the fifth most popular laboratory test for older adults, and the costs of these tests add up. In 2015, Medicare spent $337 million on vitamin D tests for seniors, up from $323 the year before.³ The claim that large proportions of North American and other populations are deficient in vitamin D might stem from misinterpretations and misapplications of the Institute of Medicine (IOM) nutrient reference values.³ Based on current evidence-based medicine guidelines, judicious ordering of this test can improve clinical outcomes while generating cost efficiencies.


TRICARE®
Provider News

Contacts
Health Net Federal Services, LLC
1-844-866-WEST (1-844-866-9378)
www.tricare-west.com

PGBA, LLC
EDI/EFT Help Desk
1-800-259-0264

Express Scripts, Inc.
Pharmacy inquiries
1-877-363-1303
www.express-scripts.com/TRICARE

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