HEALTH NET FEDERAL SERVICES
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TRICARE®

TRICARE West Region
Authorizations and Referrals

July 2023

HS0623x203 (06/23)

Learning Objectives

Health Net Federal Services, LLC (HNFS) is pleased to offer you information about our TRICARE West Region authorization and referral process.

Today you will:

- Become familiar with TRICARE's and HNFS' referral and pre-authorization process.
- Understand how to look up referral and pre-authorization requirements, submit requests and check status.
- Become familiar with online tools available to you.

HEALTH NET FEDERAL SERVICES

TRICARE®

Health Net Federal Services

Our role

As the TRICARE West Region contractor, HNFS must adhere to program manuals to administer the TRICARE benefit. However, regional contractors are allowed some discretion as to when pre-authorization or a referral may be required, and if required, how those approvals are processed.

The following information is to help providers become familiar with HNFS' processes.

About TRICARE®

What is TRICARE?

- The Department of Defense's integrated health care delivery system through military hospitals and clinics, as well as a network of civilian health care providers
- Provides health benefits and services to active duty, reservist and retired members of the uniformed services, their families and survivors
- Available to the Army, Navy, Air Force, Space Force, Marine Corps, Coast Guard, U.S. Public Health Service (USPHS), and National Oceanic and Atmospheric Administration (NOAA)

TRICARE Basics

Types of Beneficiaries

Referral and authorization requirements vary based on beneficiary and plan type

Active duty service member (ADSM) – A person currently serving in one of the seven uniformed services* of the United States; this includes National Guard and Reserve members who have been activated for a period of 30 consecutive days or more.

Active duty family member (ADFM) – A family member of an active duty service member; this includes Transitional Assistance Management Program (TAMP) and transitional survivors (spouses and children of service members killed while on active duty).

Retired service member – A former active duty service member who qualifies for benefits after retiring from service (has served 20 or more years); includes members of the retired National Guard and Reserve age 60 or over.

Retired family member – A family member of a retired service member; includes former spouses, family members of retired National Guard and Reserve members age 60 and over and survivors (spouses of service members killed while on active duty more than three years ago).

**Army, Navy, Air Force, Space Force, Marine Corps, Coast Guard, Public Health Services, NOAA*

TRICARE Plan Options

TRICARE-eligible beneficiaries have various plan options

When a patient needs care, it is important to determine upfront which TRICARE plan will be used for treatment and how that care will be reimbursed. The plan type also effects which services may be covered.

Current TRICARE Plans	
TRICARE Prime	TRICARE Young Adult
TRICARE Prime Remote	TRICARE Prime Overseas
TRICARE Select	TRICARE Prime Remote Overseas
TRICARE Reserve Select	TRICARE Select Overseas
TRICARE Retired Reserve	Continued Health Care Benefits Program (CHCBP)
TRICARE For Life	US Family Health Plan

TRICARE Prime

TRICARE Prime is a managed care (HMO-like) option

- Active duty service members must be enrolled in TRICARE Prime or TRICARE Prime Remote.*
- Other eligible TRICARE beneficiaries can choose to enroll in TRICARE Prime; enrollment occurs during Open Season or after a qualifying life event.
- Active duty service members and their families do not pay any enrollment fees or copayments.
- All other Prime enrollees pay an annual enrollment fee and may have a copayment for services.
- Care is managed by a primary care manager (PCM).
- Most specialty services require a referral from the PCM.

**TRICARE Prime Remote is a TRICARE Prime option available in remote areas for active duty service members and their family members who live and work usually more than 50 miles from a military hospital or clinic.*

TRICARE Select

TRICARE Select is a self-managed, preferred provider network (PPO-like) option

- TRICARE Select is available for TRICARE-eligible beneficiaries except active duty service members.
- Enrollment occurs during Open Season or after a qualifying life event.
- Most beneficiaries have an enrollment fee.
- Beneficiaries don’t have an assigned primary care manager and can choose to see any TRICARE-authorized provider for services covered by TRICARE, in most cases without a referral.
- Beneficiaries pay cost-shares or copayments for most services and will need to meet a certain deductible amount.

Premium-Based Plans

Those eligible to enroll in premium-based plans can do so at any time during the year

Premium-based plans are available for purchase by certain individuals who, by law, are no longer eligible for TRICARE Prime or Select due to age or inactive military status, or no longer eligible for military health care.

- TRICARE Retired Reserve (TRR)
  Available to qualified members of the retired Reserve (National Guard/Reserve) and their eligible family members. TRR offers TRICARE Select benefits.

- TRICARE Reserve Select (TRS)
  Available to qualified Selected Reserve members and their eligible family members. TRS offers TRICARE Select benefits.

- TRICARE Young Adult (TYA)
  Extends TRICARE to certain former dependent children under the age of 26 who lose TRICARE eligibility due to age (21–23). TRICARE Prime and TRICARE Select options available.

Additional Plans

These are additional plans available to beneficiaries

- TRICARE Overseas
  Beneficiaries residing overseas and seeking care stateside or beneficiaries residing stateside and seeking care overseas must coordinate all claims, referrals and authorizations through International SOS. Visit **www.tricare-overseas.com** for country-specific contact information.

- TRICARE For LIFE
  A Medicare-wraparound program available to all Medicare-eligible beneficiaries with Medicare Part A and B. This program is administered by Wisconsin Physicians Service (WPS) in the U.S. and U.S. territories. Visit **www.TRICARE4u.com**.

- US Family Health Plan (USFHP)
  An additional TRICARE Prime option. Contact **www.usfhp.com** or 1-800-74-USFHP (1-800-748-7347) for more information.

- Continued Health Care Benefit Program (CHCBP)
  CHCBP acts as a bridge between military health benefits and a new civilian health plan. It is a premium-based program for former military beneficiaries. Visit **www.HumanaMilitary.com** for more information.

Referrals

What Is a Referral?

Referrals are for services that are not considered primary care. An example of a referral is when a primary care manager (PCM) sends a patient to see a cardiologist to evaluate a possible heart problem.

The referral may be:

- **Evaluate only** – These referrals are for the initial office visit evaluation of the patient, including required diagnostic services (that do not require HNFS approval), but not treatment. HNFS will approve two office visits with the specialist to evaluate the beneficiary, and perform diagnostic services.
- **Evaluate and treat** – These referrals are for the initial office visit evaluation, required diagnostic services (that do not require HNFS approval) and treatment related to a specific medical condition. This releases care to the specialist. HNFS will approve one evaluation visit with the specialist and five follow-up visits. This type of referral includes subsequent care (diagnostic and ancillary services, related procedures) that does not require HNFS approval.
- **Procedure only** – HNFS will approve the test/procedure only.
- **Second opinion** – HNFS will approve one evaluation visit with the specialist and one follow-up visit.

Who Needs a Referral?

Not all TRICARE plan types require referrals

Who Needs a Referral

- TRICARE Prime, TRICARE Prime Remote and TRICARE Young Adult Prime beneficiaries must have a referral from their PCM before seeking most, but not all specialty care from providers other than their PCM.
- Beneficiaries in TRICARE Prime plans who seek specialty care without a referral (when required) are subject to point-of-service charges.

Who Does Not Need a Referral

- TRICARE Select, TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult Select beneficiaries do not require a referral for specialty care. *Exception:* Applied behavior analysis services require a referral for all plan types.
- TRICARE dual-eligible beneficiaries do not require a referral for specialty care.
- Beneficiaries with other health insurance (OHI) only require approval for applied behavior analysis services. (Active duty service members cannot use OHI.)

Referrals for Active Duty Service Members

What about active duty service members?

Active duty service members require a referral for all care, except:

- emergency inpatient admissions
- chemical dependency detoxification

Note: Active duty service members enrolled in TRICARE Prime Remote *do not require a referral* for urgent care due to their remote location.

Referrals for Non-Active Duty Prime Enrollees

The rules for non-active duty prime enrollees

Non-active duty TRICARE Prime/TRICARE Prime Remote beneficiaries require a referral for most, ***but not all***, specialty care.

A referral is *NOT* required for:

- Urgent care
- Ancillary services (such as laboratory, radiology and pulmonary function tests); *however, some radiology services require authorization*
- Outpatient behavioral health services *(some services require authorization)*
- Preventive care services from network providers
- Emergency services

Point-of-Service Option

The point-of-service option allows most TRICARE Prime beneficiaries to self-refer for specialty care at a higher out-of-pocket cost.

TRICARE Prime beneficiaries can use the point-of-service option to self-refer to any TRICARE-authorized network or non-network provider for covered services without referrals (when required) from their PCMs or HNFS.

- Beneficiaries who use the point-of-service option will pay a deductible and have higher cost-shares for services.
- *Active duty service members do not have the point-of-service option. T*hey may be responsible for the entire cost of self-referred care.
- The point-of-service option doesn't apply to services that don't require a referral.

Urgent Care Referral Requirements

TRICARE allows most beneficiaries to seek urgent care without a referral and without visit limits

TRICARE Prime plans

Except for active duty service members, TRICARE Prime beneficiaries do not need a referral for urgent care. Point-of-service charges will not apply when seeking urgent care from the following:

- Any network or non-network urgent care center (must be TRICARE-authorized).
- Any network primary care type provider (family practice, general practice, internal medicine, pediatrics, OB/GYN, physician assistant, nurse practitioner, or certified nurse midwife).

Active duty service members enrolled in TRICARE Prime still require a referral for urgent care; however, active duty service members enrolled in TRICARE Prime Remote do not require a referral due to their remote location.

All other plans

- There is no referral requirement for urgent care, and care may be rendered by any TRICARE-authorized (network or non-network) provider.
- TRICARE Overseas Program enrollees who are traveling and seeking stateside urgent care do not require a referral.

Pre-Authorization

Pre-Authorizations

What is an authorization?

Certain services and/or procedures require HNFS review and approval, prior to being provided. Services and/or procedures that require this approval, or pre-authorization, can include:

- Certain mental health care services
- Hospitalizations
- Surgeries
- Therapeutic procedures

Another way to think of it …

Authorizations are for non-office visits.

Referral and Pre-Authorization Requirements

Don’t Guess. Go Online.

It’s important to verify requirements before you submit!

We realize TRICARE referral and authorization guidelines can be complicated, so we offer the online **Prior Authorization, Referral and Benefit Tool** to help simplify the process.

Go to **www.tricare-west.com** > *Provider* > *Is Approval Needed* to verify referral and authorization requirements *before* submitting a request to HNFS.

We offer the following online resources to help simplify the process:

- The **Prior Authorization, Referral and Benefit** tool
- An **Ancillary Services Approval Requirements** tool

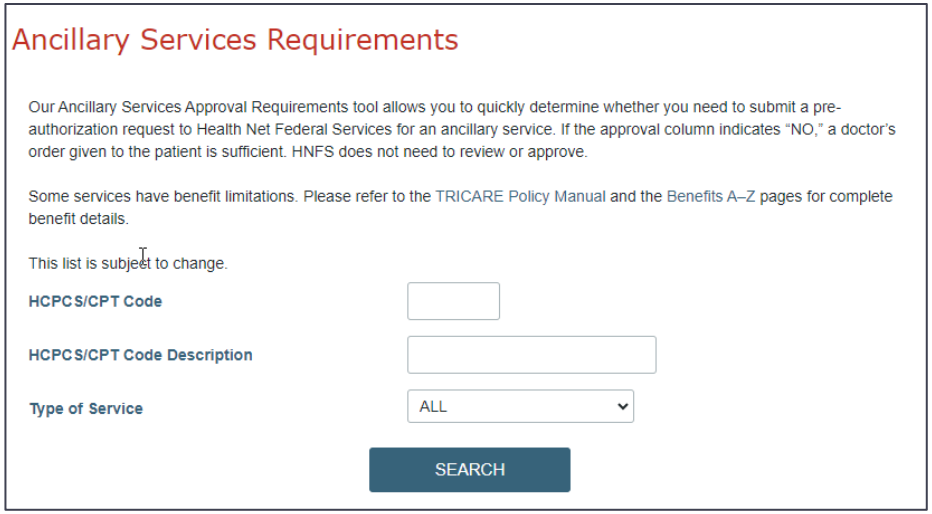
Ancillary Services

Examples: diagnostic laboratory and radiology tests (except laboratory developed tests); echocardiograms; holter monitors; pulmonary function tests; routine treadmill tests

Most ancillary services do not require a separate approval from HNFS; however, for TRICARE Prime patients, the services must be ordered by the primary care manager or a specialist the patient was approved by HNFS to see.

Use our "Ancillary Services Approval Requirements" tool for approval requirements specific to ancillary services, such as diagnostic laboratory tests and radiology.

Note: Some services have benefit limitations. Please refer to the TRICARE Policy Manual and our Benefits A–Z pages for complete benefit details.



Submitting Referral and Pre-Authorization Requests

Website Registration

Be sure to register at www.tricare-west.com

How to Register

- Click on **Log In/Register** at the top of any page at **www.tricare-west.com** to get started. This will direct you to a Website Registration Form for you to complete and fax back to us. Please allow 10 business days for processing. We will contact you to verify your information.

- ***Please only register once,*** as we are unable to support multiple accounts created by the same person. You can easily conduct transactions for multiple Tax Identification Numbers under one user name.

Why Register?

- Registration provides you access to all the self-service tools on our website.

- You'll be automatically opted in to receive TRICARE and HNFS-specific educational updates. *You can opt out at any time by managing your account preferences or clicking the opt out link at the bottom of all email messages.*

For web support, call the HNFS Web Admin Support team at 1-800-440-3114

Routine, Urgent or Emergent

Most referral requests are considered routine.

- **Routine:** A routine request is when care is needed within the four-week TRICARE specialty care access standards. Nearly all referral requests are routine unless the patient needs care in less than 72 hours.
- **Urgent:** A medically urgent request is when care is needed within 24–72 hours.
- **Emergent:** A medically emergent request is when care is needed within 24 hours or less.

Submitting Requests Online

HNFS requires providers to submit referral and pre-authorization requests online

When you submit, be sure to:

- Complete all required fields.
- Be clear and concise when providing clinical information. We offer Letters of Attestation for certain limited benefits that can be submitted in lieu of clinical documentation.
- Include the complete name and address when requesting a specific provider. *Do not abbreviate.*
- Use the attachment feature (in CareAffiliate®) to include supporting documentation.

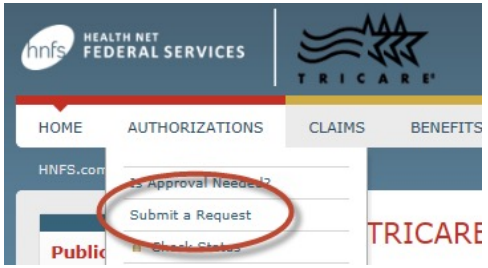
We offer a video tutorial, step-by-step user guides and referral/authorization-specific webinar presentations at **www.tricare-west.com** > *Provider* > *Education*.

Two Submission Options

HNFS offers two online submission options: CareAffiliate® and the Web Authorization Referral Form.

Find our two online submission tools at **www.tricare-west.com** > *Provider*.

If not already logged in, click on **Submit a Request** from the drop-down menu.



You will see two options.

- CareAffiliate (preferred method, requires website registration)
- Web Authorization/Referral Form (WARF)

CareAffiliate (requires login)	Web Authorization/Referral Form (does not require login)
Key features of this option include: • provides immediate responses • can be used for outpatient and inpatient requests • use to check status of requests • save frequently used providers, request profiles and diagnosis lists • allows for attachments After clicking the "Submit" button below, you will be directed to our secure portal. From there, click on "Submit Authorization Request" to access CareAffiliate. Submit an Authorization or Referral Now Tip: Use our step-by-step CareAffiliate Guide as a resource.	Key features of this option include: • does not require website registration • can be used for outpatient requests only • provides the option to print and save a PDF Submit an Authorization or Referral Now Tips: • Use our step-by-step WARF Guide and the Request Type Guide. • Be sure to use the provider lookup feature when requesting a provider. • Do not select "multi-specialty" as a specialty. This will delay processing of your request.

Using CareAffiliate

HNFS' preferred referral/pre-authorization submission method

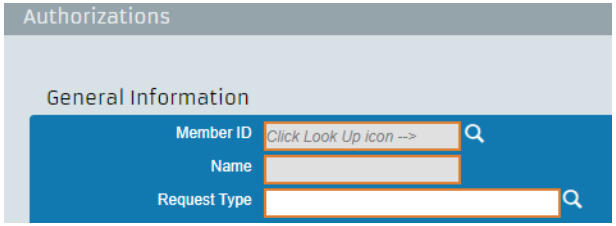
While both online submission options allow you to submit requests and receive immediate responses, there are advantages to using CareAffiliate:

Key features of this option include:

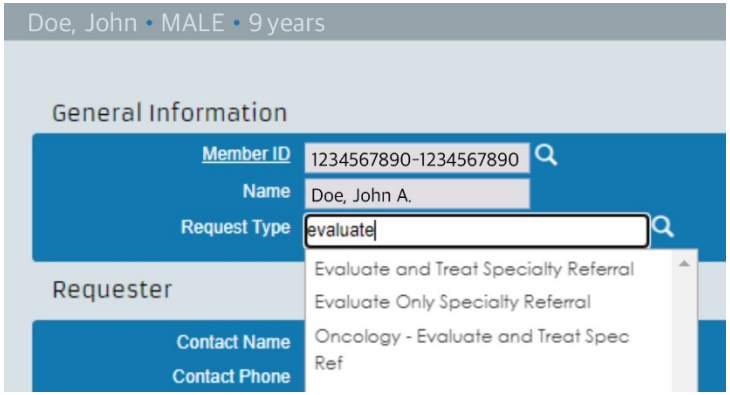
- Use for outpatient and inpatient requests (WARF only supports outpatient requests)
- Use to check status of requests
- Save frequently used providers, request profiles and diagnosis lists
- Add attachments

Submission Tips

1. Use Google Chrome or Microsoft Edge for best results.
2. Clear all cookies/website data.
3. There are multiple ways to search: magnifying glass icon, drop-down menus, “type-ahead” fields, and “wild card” searches using asterisks.



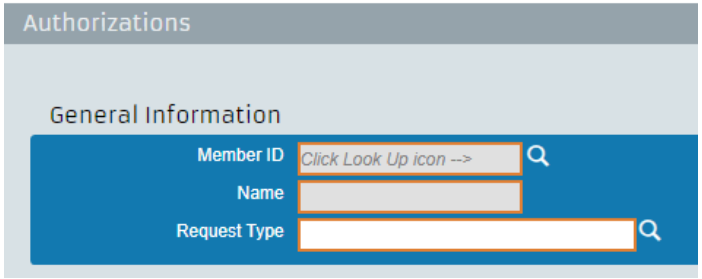
4. Certain fields, such as member and requesting provider, have links displayed to the left that allow you to view more details.
5. Fields outlined in orange are required fields. If a field is grayed out, it means it is locked and cannot be edited.



Request Types

Pre-populated templates save you time.

Request types are templates created by HNFS for referral and pre-authorization submissions. Each request type has specified codes/code ranges that will pre-populate in the request.

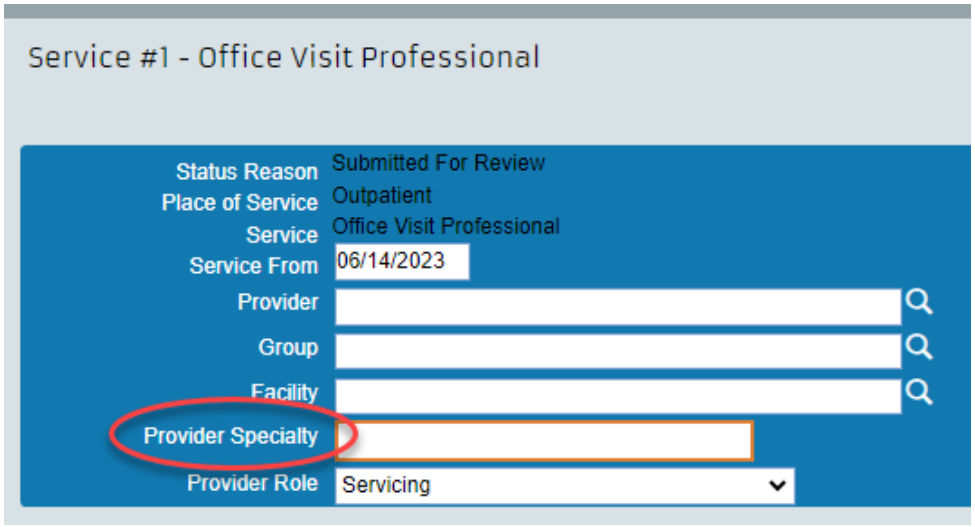


Tip: *Do not use "Evaluate and Treat" request types for therapies (for example, physical therapy) or mental health services.*

Use the **Request Type Guide** located at **www.tricare-west.com** > *Provider > Education/Quick Reference Charts* for assistance.

Servicing Providers

If you do not have a specific servicing provider in mind, enter the provider specialty and HNFS will locate one for you.



How We Approve

Use the Request Type Guide to see approved code ranges.

Our online authorization and referral tools use request types for different services.

- In many of the standard request types, HNFS will authorize a range of codes. In these instances, codes that fall within that range are also authorized.
- Certain request types have one or more single codes populated on a service line. In these instances, HNFS will only authorize the single code.

Excerpt from the Request Type Guide

Allergy Services	95004, 95017–95117	P9
Ambulance Services	A0999	P10
Audiology	92550, 92552–92557, 92563–92588	P11

Processing Time Frames

- **We process routine requests within 2–5 business days and medically urgent requests in an expedited manner.** Please do not re-submit requests, as this will cause delays in processing.

- **If we need additional information to make a determination, we will notify the requesting provider.** Please remind your patients to not schedule appointments if they are still awaiting a response on new requests submitted to HNFS.

Additional Information Requests (AIR)

When reviewing pre-authorization requests for limited benefits, we may need additional information.

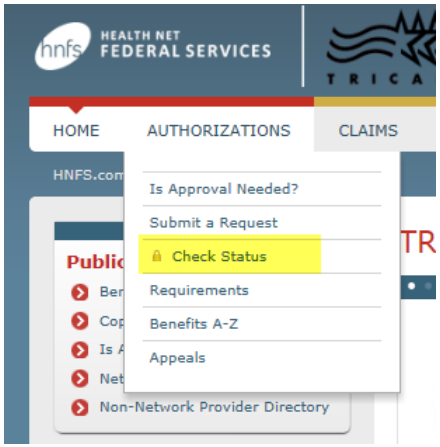
You can help prevent AIRs by proactively submitting a Letter of Attestation (if available) to all limited benefit review requests.

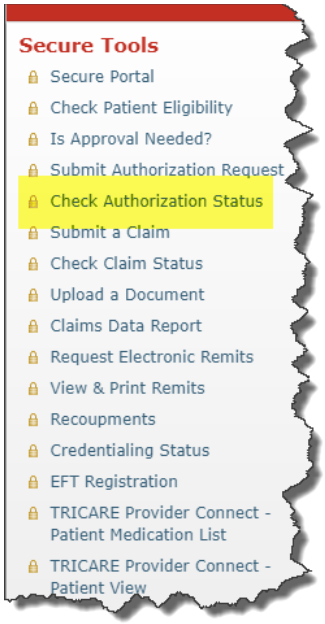
- If needed, HNFS will fax an AIR letter to the requesting provider.
- The AIR letter includes a description of the information needed and the timeframe in which the provider needs to respond usually within 30 days of the initial request received.
- The provider should fax additional information to our secure fax line at 866-678-0615.
- If additional information is not received within the timeframe specified, the authorization request will be canceled. *A new authorization request will need to be submitted with all supporting documentation.*

Status

Check status online.

To check status from the main website, go to **www.tricare-west.com** > *Provider* > *Authorizations* > *Check Status (log in required).*

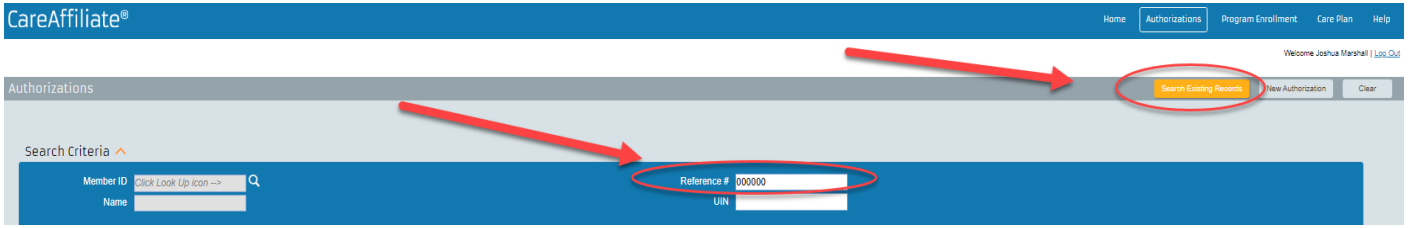




Tip: We offer a *Using the Authorization Status Tool* guide with step-by-step instructions at **www.tricare-west.com** > *Providers* > *Education … Quick Reference Guides*

Status continued

To check status in CareAffiliate, from the Authorizations tab, click on Search Existing Records.



The main status will show (for example, "Pended"). To view additional details on the status reason, click on the Reference # on the search results screen and then click on ***each*** Service Line.

Status continued

Main Status Description	Status Reasons
Pended	HNFS is still processing the request.
Auto Terminated (pending for)	Care Radius-generated term for when a request automatically pends for additional review. This does not mean the same as canceled or denied!
Approved	All requested services were approved.
Modified	Some but not all requested services were approved.
Denied	All requested services were denied.
Canceled	The request was canceled. Look in the Detailed Status Description for the specific cancel reason.

Common Detailed Status Description (not a complete list)	Status Reason
Certified in Total	Approved
Not Certified	Some or all codes (or ranges of codes) were denied
Duplicate	Duplicate to a request already in the system

The Right of First Refusal

Your patients may be required to seek care at a military hospital or clinic

- Requests for specialty care, inpatient admissions or procedures requiring pre-authorization will be directed to military hospitals or clinics first, followed by TRICARE network providers if the services are not available at the military hospital or clinic.

- In order to minimize beneficiary dissatisfaction, and to reduce any confusion as to who will render care, please refrain from advising your patients where their specialty care will be rendered.

- Instead, advise that a referral for specialty care has been submitted and he or she will be contacted by the military hospital or clinic, or HNFS, as to where care may be obtained.

Active Referrals

- **Active:** A referral is considered *active* if it is less than 180 days old for an active duty service member (ADSM), or less than 365 days old for a non-ADSM. A military hospital or clinic may specify a longer duration for ADSMs, not to exceed one year.

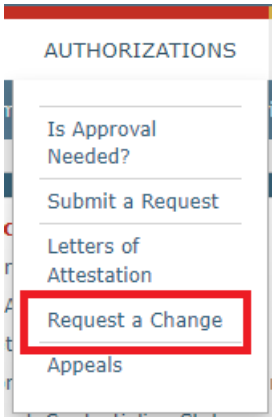
  Note: The active referral 180/365 day duration is calculated from the receipt date of the last military or civilian PCM referral.

- **Validity dates/visits:** Referrals are valid for the time frame specified and only for the number of visits specified. Specialty care received outside the scope of an approved referral may be processed as Point of Service.

Changes to Existing Referrals

Providers can request certain changes on already-approved outpatient referrals and authorizations as long as services haven't been rendered. Request a change online using HNFS' **Authorization Change Request Form** at **www.tricare-west.com** > *Providers* > *Authorizations* > *Request a Change*.

Keep in mind, HNFS may authorize a range of CPT® or HCPCS codes rather than listing individual service codes on separate service lines. Always verify the code wasn't already approved and/or whether an approval is needed before submitting a change request to HNFS.



The following types of changes *can* be requested online:

- Servicing provider
- Priority of the request *(for example, urgent to routine)*
- CPT® or diagnosis codes *(some exceptions apply)*
- Procedure/surgery/service date(s)

This tool *cannot* be used :

- If it's been more than 30 days since HNFS approved the services
- To add services to or extend visits/units on active approved authorizations
- If services were already rendered
- To submit medical documentation
- To submit questions to customer service
- To request changes to applied behavior analysis referrals/authorizations

Note: *Beneficiaries can request specialty provider changes through the Check Status tool at* ***www.tricare-west.com.***

Additional Services

Who submits the request to HNFS? Specialist or PCM?

Situation	PCM or Specialist	Notes
Specialist is requesting additional services beyond what HNFS originally approved	Specialist	It is the responsibility of that specialist (not the referring PCM) to verify requirements and, if required, submit a new request to HNFS.
Specialist is requesting a continuation of care extension	Specialist (if the original referral from the PCM has not expired)	This will not extend the episode of care; it will only add additional visits
Specialist needs to refer the patient to another specialty provider	Specialist	The specialist must submit a new request to HNFS for approval using the same diagnosis codes on the original PCM-to-specialist referral. Right of first refusal rules apply.
The original PCM referral expires during treatment.	PCM	The PCM must submit a new request to HNFS for approval.
There is a change in diagnosis.	PCM	If there is a change in diagnosis, a new PCM referral is required, as all new episodes of care require a new referral.

Episode of Care Examples

Let's review some examples

Example 1: The PCM refers a retired service member with chest pain to a cardiologist, specifying "evaluate and treat." In order to make a complete assessment, the cardiologist orders an echocardiogram, a holter monitor and a routine treadmill test as part of the evaluation. *The cardiologist does not need a separate approval from HNFS to perform these services.* ***Why?***

1. The PCM specified "evaluate and treat" on the original referral.
2. Echocardiograms, holter monitors and routine treadmill tests do not require prior authorization for this beneficiary category.
3. The services are TRICARE covered benefits.
4. The cardiologist performed the services within the duration of the approved PCM referral.

Tip: For the same reasons, the cardiologist may also perform outpatient cardiac catheterization procedures to diagnose and/or treat the heart condition without requesting approval from HNFS.

Example 2: The cardiologist in Example 1 identifies the need for surgical intervention as a result of cardiac catheterization findings. The patient must now be referred to a cardiothoracic surgeon. In this case, *the cardiologist must submit a new referral request to HNFS*. ***What changed?***

1. The original specialist (the cardiologist) does not perform the needed service and is enlisting evaluation from a new type of specialist (cardiothoracic surgeon). Therefore, a new referral is required.
2. This new referral must also go through the ROFR process and be reviewed for military hospital/clinic capability and capacity.

Consult Reports (Also Known as Clear and Legible Reports)

Consult Reports or Clear and Legible Reports (CLRs)

Network providers treating TRICARE patients who were referred by a military hospital or clinic, will need to submit consult documentation – also known as patient encounter reports or clear and legible reports (CLRs) – to the referring provider within required time frames. Consult documentation includes consultation reports, care notes, operative reports, and discharge summaries.

We encourage you and your staff to check out our online module, "Returning Consult Documentation for Your TRICARE Patients" at **www.tricare-west.com** > *Provider* > *Take Me To …* *Returning Consultation Reports.* The module, which takes less than 10 minutes to complete, covers:

- Why consult reports are important
- The patient continuum of care
- Timeliness standards for returning consult documentation
- Where and how to submit consult documentation to military hospitals and clinics.

Consult Reports or Clear and Legible Reports (CLRs) continued

Visit **www.tricare-west.com** *> Provider > Take Me To … Returning Consultation Reports*

As a reminder, once you have rendered care, the "clock" for returning consultation or initial assessment documentation begins.

Consultation Type	Consultation Standard
Emergent care	Send within 24 hours
Urgent care	Send within 48 hours
All others (*except mental health)	Send within seven business days
Mental health assessment	Mental health care providers: Submit brief initial assessments within seven business days.

Provider Resources

Online Resources

Find TRICARE West Region-specific resources at **www.tricare-west.com** > *Provider > Education/Quick Reference Charts.*

- Submitting TRICARE Authorization and Referral Requests: Provider Resources fact sheet
- Request Type Guide
- CareAffiliate® User Guide
- Web/Authorization Referral Form (WARF) User Guide
- Prior Authorization, Referral and Benefit Tool User Guide
- Using the Authorization Status Tool

We also offer live and recorded webinars at **www.tricare-west.com** *> Provider > Education/TRICARE Webinars.*

Q&A

HEALTH NET FEDERAL SERVICES
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