HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

# TRICARE®
# West Region Provider Handbook

*Your guide to TRICARE programs, policies and procedures*

January 1–December 31, 2024

## An Important Note About TRICARE Program Information

This TRICARE West Region Provider Handbook will assist you in delivering TRICARE benefits and services. At the time of publication, January 1, 2024, the information in this handbook is current. It is important to remember that TRICARE policies and benefits are governed by public law, federal regulation and the Government's amendments to Health Net Federal Services, LLC's (HNFS') managed care support (MCS) contract. Changes to TRICARE programs are continually made as public law, federal regulation and HNFS' MCS contract are amended. For up-to-date information, visit **www.tricare-west.com**.

Contracted TRICARE providers are obligated to abide by the rules, procedures, policies and program requirements as specified in this TRICARE West Region Provider Handbook, which is a summary of the TRICARE regulations and manual requirements related to the program. TRICARE regulations are available on the Defense Health Agency (DHA) website at **www.tricare.mil**. If there are any discrepancies between the TRICARE West Region Provider Handbook and TRICARE Manuals (Manuals), the Manuals take precedence.

## Using This TRICARE West Region Provider Handbook

This TRICARE West Region Provider Handbook has been developed to provide you and your staff with important information about TRICARE, emphasizing key operational aspects of the program and program options. This handbook will assist you in coordinating care for TRICARE beneficiaries. It contains information about specific TRICARE programs, policies and procedures. TRICARE program changes and updates may be communicated periodically through *TRICARE Provider News* and other email and/or online publications. The TRICARE West Region Provider Handbook is updated annually and as required. Thank you for your service to America's heroes and their families.

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# Welcome to TRICARE® and the West Region

Thank you for supporting our uniformed services members, retirees and their families in the TRICARE West Region (West Region) as a TRICARE network provider. TRICARE covers a wide range of health care benefits you help deliver as we carry on the vital mission of the TRICARE program. Together, we can continue to provide health care excellence for our nation's best.

## What is TRICARE?

TRICARE is the worldwide health care program available to eligible beneficiaries of the eight uniformed services – the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Space Force, U.S. Marine Corps, U.S. Coast Guard, U.S. Public Health Service, and the National Oceanic and Atmospheric Administration. TRICARE-eligible beneficiaries may include active duty service members (ADSM) and their families, retired service members and their families, National Guard and Reserve members and their families, survivors, certain eligible former spouses, and others.

TRICARE brings together military and civilian health care professionals and resources to provide high-quality health care services. The program is managed in two stateside regions in the U.S. – TRICARE East Region (East Region) and West Region. In these U.S. regions, TRICARE is jointly managed by the Defense Health Agency (DHA) and the TRICARE Health Plan (THP). DHA has partnered with civilian regional contractors in the East and West Regions to assist TRICARE regional directors and military hospital and clinic commanders with operating an integrated health care delivery system.

## Your Regional Contractor

As the regional contractor in the West Region, Health Net Federal Services (HNFS), a wholly-owned subsidiary of Centene Corporation, administers the TRICARE program in Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (except the Rock Island Arsenal area), Kansas, Minnesota, Missouri, (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (Amarillo, Lubbock and El Paso areas only), Utah, Washington, and Wyoming.

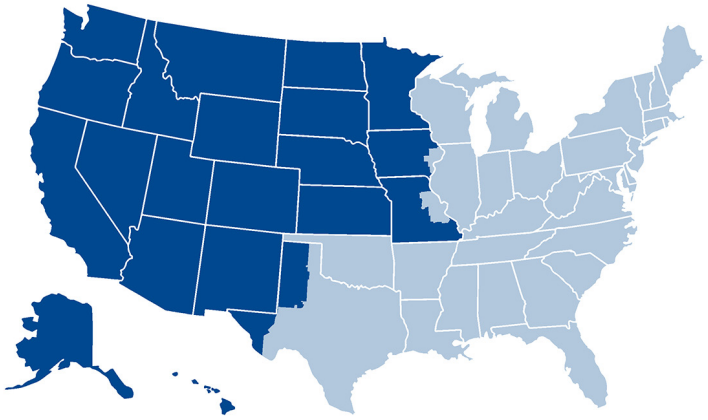
As the longest serving regional contractor for TRICARE, we are dedicated to ensuring the program is a successful experience for all beneficiaries and network providers.

## TRICARE Regions

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

**East Region**
Humana Military
**1-800-444-5445**
**www.humanamilitary.com**
**www.tricare-east.com**

**WEST Region** EAST Region



## Health Net Federal Services TRICARE Contract Administration

HNFS develops and maintains the medical/surgical network and mental health network. Our partner, PGBA, LLC (PGBA), provides and maintains claims processing and claims customer service.

# TRICARE West Region Website

HNFS' website, **www.tricare-west.com**, provides information about TRICARE benefits, processes, requirements, and operations in the West Region, as well as access to self-service tools. Some tools require login.

Visit the provider section of **www.tricare-west.com** to:

*This list is not all-inclusive*

- Verify a beneficiary's TRICARE eligibility, other health insurance (OHI) status and out-of-pocket expenses (deductibles, copayments, cost-shares).
- Check pre-authorization and referral requirements.
- Find and print information on benefits and costs.
- Access the Primary Care Manager (PCM) Enrollee Roster for a list of beneficiaries enrolled to a PCM.
- Submit and check the status of pre-authorization and referral requests.
- Upload attachments such as forms and medical documentation.
- Submit and check the status of claims.
- Create claims data reports to view beneficiary claims history, set up electronic funds transfer (EFT) and view remits.
- Update provider demographics.
- Use TRICARE Provider Connect – Patient View to access patient health information online.
- Use the TRICARE Provider Connect – Patient Medication List to review medications prescribed to your TRICARE patients.
- View the *TRICARE West Region Provider Handbook* quick reference charts and *TRICARE Provider News*.
- View/print forms.
- Read important updates about the TRICARE program and HNFS processes.
- Submit secure electronic mail questions using *Ask Us*.

## Website Registration

HNFS encourages website registration to streamline your web experience and provide access to secure tools for your TRICARE transactions. Start by clicking on "Register" at the top of any web page. By registering, you are also electing to receive TRICARE-related email communications (options to opt out of emails are available).

## Electronic Claims

TRICARE requires network providers to submit claims electronically using the appropriate *Health Insurance Portability and Accountability Act* (HIPAA)-compliant standard electronic claims format. Paper claims submitted by a network provider may be returned to the provider with directions to submit electronically.

**Note:** Except for applied behavior analysis (ABA) providers, TRICARE network providers in Alaska are not required to submit claims electronically.

Electronic data interchange (EDI) Payer ID: 99726

Benefits of filing claims electronically:

- Improved cash flow – on average, TRICARE processes electronic claims two to three weeks faster than paper claims
- Reduced postage and paper-handling costs
- Elimination of data entry errors

Providers registered at **www.tricare-west.com** can file new and corrected claims through XPressClaim®. XPressClaim allows providers to submit 1500 and UB-04 claims and receive instant payment results for a majority of claims. Providers can also print a patient summary receipt while their patient is still in the office. There is no cost to use XPressClaim. Register at **www.tricare-west.com** to begin using XPressClaim now.

## Electronic Funds Transfer

You can sign up for EFT at **www.tricare-west.com**. Registering for EFT requires having signature authority. This means you are authorized to disburse funds; sign checks; and add, modify, or terminate bank account information.

# Online Network Provider Directory

HNFS' online **Network Provider Directory** makes it easy for beneficiaries and providers to locate West Region network providers. Network providers must satisfy all applicable credentialing requirements and execute a Provider Participation Agreement to be listed in the **Network Provider Directory**. Provider details displayed in our directory include: location, provider name, provider type, specialty, gender, accepting new patient status, telemedicine capability, office phone/fax numbers, and additional language(s).

Please visit the online **Network Provider Directory** to confirm your individual listing(s) is/are accurate. Keep in mind, certain specialties may be credentialed by HNFS at the individual level but only listed in the **Network Provider Directory** at the group level. Similarly, HNFS must credential all network nurse practitioners and physician assistants, but only those identified as primary care managers (PCMs) will display in the **Network Provider Directory**.

Please review ***"Updating Provider Information"*** in the ***Important Provider Information*** section for instructions on updating your directory record.

If you do not find your listing in the **Network Provider Directory**, but wish to be listed, contact HNFS' customer service line at **1-844-866-WEST (1-844-866-9378)**.

If HNFS determines a listing in the **Network Provider Directory** is inaccurate or is missing required TRICARE program data elements, HNFS may be unable to publish the provider listing until accurate information has been provided and updated

in our system. There are seven required data elements for publication in the **Network Provider Directory**:

1. Provider name
2. Provider specialty
3. Sub-specialty (if applicable)
4. Gender
5. Work practice address
6. Work practice fax number
7. Work practice telephone number for each service area

Information in the **Network Provider Directory** is subject to change without notice. Providers should encourage TRICARE beneficiaries to call and confirm a network provider is accepting new TRICARE patients before making appointments. Additionally, providers should submit a **Network TRICARE Provider Roster** or contact us to let us know if their status for accepting new patients has changed.

## Mental Health and Applied Behavior Analysis Provider Search

Beneficiaries and providers can use the **Network Provider Directory** to locate network mental health care and ABA providers in the West Region. The **Network Provider Directory** allows users to search by specialties such as "Mental Health Counselor – Supervised," "Psychiatry – Child and Adolescent" and "Office Based Opioid Treatment." ABA supervisors are listed as "Behavioral Analyst – Master's Level or PhD, ABA." You also can search for ABA providers in the **Autism Care Demonstration (ACD) Provider Directory**.

**Note:** Assistant behavior analysts and behavior technicians are not listed separately in the **Network Provider Directory** or the **Autism Care Demonstration (ACD) Provider Directory**.

## Telemedicine

HNFS' **Network Provider Directory** includes a telemedicine filter to allow beneficiaries to easily connect with providers who can see them via virtual appointments. If you have providers in your practice who offer video telemedicine (also referred to as telehealth) services, submit a **Network TRICARE Provider Roster template** or contact us to let us know.

**Note:** Currently, we are not identifying providers who offer audio-only telemedicine services.

HNFS also partners with several companies for telemedicine services. Visit our **Telehealth Options** page to learn more.

**Note:** HNFS' telehealth partners are subject to change.

## Directory Ratings

To assist beneficiaries and providers in the selection of practitioners, HNFS offers information on physicians and other health care providers through various rating icons within its **Network Provider Directory**. Keep in mind, if a physician or other health care provider does not have a rating designation, it does not mean the provider does not offer quality care. All network providers must meet TRICARE's and HNFS' stringent quality and credentialing requirements.

### *RowdMap by Cotiviti*

HNFS has partnered with RowdMap, a recognized analytics company, to help us rank providers based on their patterns of clinical practice. According to RowdMap criteria, high-value providers:

- Demonstrate thoughtful use of diagnostic tests and procedures.
- Begin with conservative care, performing surgery or other maximally intensive options only when the outcome is likely to be better than alternative treatment options.
- Perform more procedures that represent better value than his or her peers.
- Perform surgery on appropriate patients in the optimal setting with fewer complications and readmissions (surgeons only).
- Manage pain with lower-risk medications.
- Align with other high-value providers in their geographic area.

HNFS designates high-value providers with a RowdMap rating of 1 or 2 (out of 5) with a gold star in its **Network Provider Directory**. Visit **www.cotiviti.com** for additional information.

### *Patient-Centered Medical Home Designation*

The Patient-Centered Medical Home is a model of care that puts patients at the forefront of care. Patient-Centered Medical Homes are designed to build better relationships between people and their clinical care teams, resulting in improved quality, patient experience and staff satisfaction, all while reducing health care costs. The National Committee for Quality Assurance (NCQA), a private, nonprofit organization dedicated to improving health care quality, accredits and certifies a wide range of health care organizations. Its Patient-Centered Medical Home Recognition program highlights primary care providers who have made a commitment to:

- Helping patients understand treatment options, acting as a partner in decisions about care.
- Promoting access through expanded hours and telemedicine.
- Having providers work in teams to prevent problems and manage chronic conditions to keep patients healthy.

HNFS uses the NCQA emblem to designate NCQA Patient-Centered Medical Home recognition in the **Network Provider Directory**.

Providers listed with this icon have achieved level 2 and 3 NCQA recognition (NCQA uses three levels, with level 3 being the highest).

Visit **www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/** to learn more about NCQA's Patient-Centered Medical Home Recognition program.

*Provider Readiness Designation (Military Culture Awareness)*

Mental health care providers who have earned the Department of Defense's (DOD) provider readiness designation have specific knowledge of military culture and treatment of mental health issues among members of the Armed Forces. Beneficiaries and providers can search the **Network Provider Directory** specifically for mental health care providers who have this designation by checking the "Military culture awareness" box in the Provider Details section of the directory search page. HNFS indicates providers who have earned the provider readiness designation with a medicine bag icon in its **Network Provider Directory**.

To receive the provider readiness designation, mental health care providers must fulfill the following military culture training requirements established by the DOD:

- Military culture training course – Military Culture: Core Competencies for Health Care Professionals (Module 1 only), available at **https://deploymentpsych.org/military-culture-course-modules**
- The following three evidence-based treatment courses, available at **https://deploymentpsych.org/online-training-courses**:
  1. *Cognitive Processing Therapy for Posttraumatic Stress Disorder (PTSD) in Veterans and Military Personnel*
  2. *Prolonged Exposure (PE) Therapy for PTSD in Veterans and Military Personnel*
  3. *Depression in Service Members and Veterans*

These training opportunities are offered by the Center for Deployment Psychology of the Uniformed Services University of the Health Sciences.

The DOD provides HNFS lists of the providers who have earned this designation. Refer to "***Value-Based Incentives***" in the ***Important Provider Information*** section for more information.

### Non-Network Provider Listing

The online **Non-Network Provider Directory** offers non-network doctors, hospitals and other health care professionals in the West Region. Non-network providers do not have a signed agreement with HNFS. Provider information in the **Non-Network Provider Directory** is listed as submitted by the provider and may be up to 16 months old.

## West Region Customer Service Line

HNFS encourages providers to use web-based tools to check beneficiary eligibility, validate whether a service requires pre-authorization, submit and check status for pre-authorization and referral requests, and check claims status. For additional assistance, providers can call the HNFS toll-free customer service line, **1-844-866-WEST (1-844-866-9378**), Monday through Friday, 5 a.m. to 9 p.m. PT, for general assistance.

Additionally, this phone number offers an interactive, automated telephone menu, giving beneficiaries and providers access to many self-service features 24 hours a day, seven days a week. Follow the prompts to verify beneficiary eligibility, check claims status and review pre-authorization and referral requests.

## TRICARE Provider Engagement Specialists

To benefit a provider's practice and patients, HNFS is dedicated to making sure the **Network Provider Directory** has the most up-to-date information.

TRICARE Provider Engagement Specialists may contact network provider locations via phone or email to ensure TRICARE Program comprehension and verify demographic information. Provider Engagement Specialists also perform outbound calls to assist with onboarding new providers or groups and verify receipt of the Welcome Toolkit for newly contracted providers.

Additionally, Provider Engagement Specialists serve as educators, offering current information on TRICARE, referral and authorization processes, reimbursement methodologies, claim submission requirements, and fee and payment resolution. Provider Engagement Specialists usually contact providers by telephone and email and offer instructive web-based sessions to all provider types.

## TRICARE Provider News

HNFS offers network providers its quarterly online newsletter, **TRICARE Provider News**, which includes articles about important TRICARE benefits and updates and tips for submitting pre-authorization and referral requests and filing claims. To view new and archived issues, visit **www.tricare-west.com**.

## Provider Resources, Figure 1.1

| Resource | Description | Contact Information |
|---|---|---|
| **Benefits and Beneficiary Costs** | Verify TRICARE benefits and beneficiary financial responsibility. | **www.tricare-west.com**<br>**1-844-866-WEST (1-844-866-9378)** |
| **Case Management** | Coordinates the beneficiary's health care between military hospitals and clinics, providers and other health care and community resources based on appropriate needs and availability of required services. | Case Management<br>PO Box 9528<br>Virginia Beach, VA 23450-9528<br>**Fax: 1-888-965-8438** |
| **Claims** | Submit claims, check status, and view provider remits. | **www.tricare-west.com**<br>**1-844-866-WEST (1-844-866-9378)**<br>**1-800-259-0264**<br>(EDI claims) |
| **CPT® Coding Manual** | Request copies or obtain assistance. | American Medical Association<br>515 N. State Street<br>Chicago, IL 60654<br>**1-800-621-8335**<br>**www.ama-assn.org** |
| **Eligibility** | Verify TRICARE beneficiary eligibility. | **www.tricare-west.com**<br>Automated phone menu options:<br>**1-844-866-WEST (1-844-866-9378)** |
| **Fraud and Abuse** | Anonymously report suspected fraud or abuse to HNFS. | **www.tricare-west.com**<br>**1-844-886-2206**<br>**Fax: 1-844-734-1266** |
| **ICD-10 Diagnosis Coding Manual and HCPCS Manual** | Request copies or obtain assistance. | Optum360™<br>2525 Lake Park Boulevard<br>Salt Lake City, UT 84120<br>**1-800-464-3649**, option 1<br>**www.optumcoding.com** |
| **DHA-Great Lakes** | Contact DHA-Great Lakes (DHA-GL). DHA-GL supports remotely-located active duty, Reservist, and National Guard service members in the Army, Navy, Marine Corps, Air and Space Force, and Coast Guard who receive health care through civilian health care systems. DHA-GL also provides support to other service member populations such as new recruits en route to their first permanent duty station. DHA-GL functions include, but are not limited to, pre-authorization of specialty care, dental care and claim payment determinations. | Defense Health Agency-Great Lakes<br>PO Box 886999<br>Great Lakes, IL 60088-6999<br>**1-888-647-6676**<br>**https://tricare.mil/greatlakes** |
| **Pharmacy Services** | Get help with pharmacy-related services, including claims, pre-authorizations, and requirements. | Express Scripts, Inc.<br>PO Box 52132<br>Phoenix, AZ 85072<br>**1-877-363-1303**<br>**Fax: 1-877-895-1900**<br>**www.militaryrx.express-scripts.com** |
| **Pre-authorization/ Referral Requests** | Request pre-authorizations and referrals from HNFS. | **www.tricare-west.com**<br>For emergent requests, providers may submit online or call:<br>**1-844-866-WEST (1-844-866-9378)** |
| **Pre-authorization/ Referral Requirements** | Determine if an approval from HNFS is required. | **www.tricare-west.com** |
| **Pre-authorization/ Referral Status** | Check request status. | **www.tricare-west.com**<br>Automated phone menu options:<br>**1-844-866-WEST (1-844-866-9378)** |
| **Credentialing Status, Demographic and Tax Identification Number (TIN) Updates** | Check network credentialing status and update demographics and TINs. | **www.tricare-west.com**<br>Credentialing status:<br>**1-844-866-WEST (1-844-866-9378)** |
| **TRICARE Rates and Reimbursement** | View and download TRICARE-allowable charge schedules including CHAMPUS Maximum Allowable Charges (CMAC), diagnosis-related groups (DRG) rates, etc. | **www.health.mil** |
| **TRICARE For Life (TFL)** | Get help with TFL benefits, claims and requirements. | Wisconsin Physicians Service/<br>TRICARE For Life<br>PO Box 7889<br>Madison, WI 53707-7889<br>**(general correspondence only, no claims)**<br>**1-866-773-0404**<br>**1-866-773-0405 (TDD)**<br>**www.TRICARE4u.com** |

## *Choosing Wisely®*

*Choosing Wisely*, an initiative of the American Board of Internal Medicine (ABIM) Foundation from 2012-2023, helped generate conversations between clinicians and patients about what tests, treatments and procedures were needed – and which ones were not. Choosing Wisely explored and inspired ways to reduce overuse and unnecessary services and improve patient outcomes. Beneficiaries, providers, and MTF staff can access *Choosing Wisely* content in the "Wellness" sections at **www.tricare-west.com**.

*Choosing Wisely* has generated several conversations in the exam room and across the health system, stimulated thousands of journal articles, inspired more than two dozen similar campaigns in other countries, and influenced many projects that explored ways to reduce overuse and unnecessary services and improve patient outcomes. The program and information are located at **www.choosingwisely.org**, where you can learn more about *Choosing Wisely's* impact on healthcare. Through the creation of training modules and programs like *Choosing Wisely STARS, Choosing Wisely* became a key tool in medical training and professional development.

You can still be a *Choosing Wisely* champion. Many providers have implemented *Choosing Wisely* by educating their staff and patients about the benefits, purpose and goals of appropriate use of tests, treatment and procedures by establishing an implementation plan, tracking data and using it to understand and improve performance. Remember to engage your patients in the conversation and empower them to choose the most effective care for their situations.

# Healthcare Effectiveness Data and Information Set

HNFS is committed to quality improvement. To measure quality and improve performance, HNFS utilizes Healthcare Effectiveness Data and Information Set (HEDIS) measures. These measures, developed by the NCQA, are used by more than 90% of America's health plans to measure performance on important dimensions of delivery and service.

HNFS monitors and assesses network and physician performance on the following:

- Colorectal cancer screening
- Diabetes care – annual HbA1c testing
- Mental health aftercare – 7 and 30-day follow up
- Well-child visits
- Medication management for people with asthma
- Rehospitalization within 30 days of acute inpatient discharge
- Emergency department utilization
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications

Our aim is to provide the information, resources and support needed to help our providers deliver the best care available to beneficiaries. Each year we strive to make substantial improvements in performance on all measures, which is something we cannot accomplish without our network of dedicated providers. For information on coverage for preventive services, refer to the "***Medical Coverage***" section of this handbook. To learn more about HEDIS, visit our **Clinical Quality Initiatives** page at **www.tricare-west.com**.

### Provider Connect – Patient View

*Provider Connect – Patient View* is a free, online tool on the secure provider portal at **www.tricare-west.com** that provides civilian primary care managers (PCM) and their staff data to help achieve cost and quality of care improvements.

*Provider Connect – Patient View* offers integrated outreach tools to alert PCMs about gaps in patient care and provide patient-specific care recommendations. Visit **www.tricare-west.com** and **www.changehealthcare.com** for more information.

# National Disaster Medical System

As health care providers, medical/surgical facilities are in the unique position to offer key resources in times of disaster and public health emergencies. Your part as a member of the Disaster Medical Assistance Team (DMAT) – working within the National Disaster Medical System (NDMS) to provide critical aid in times of natural disasters, major transportation accidents, technological disasters, and acts of terrorism – ensures the availability of qualified public health and medical assistance in times of crisis.

You are encouraged to become a member of NDMS. Learn more about this invaluable service by visiting the **NDMS** website.

To learn more about the requirements for you or your hospital to become part of a DMAT or to register, visit **The Emergency System for Advance Registration of Volunteer Health Professionals** website.

# Important Provider Information

## TRICARE Policy Resources

The Defense Health Agency (DHA) provides Health Net Federal Services (HNFS) with guidance – as issued by the Department of Defense (DOD) – for administering TRICARE-related laws. The DOD issues this direction through modifications to the **Code of Federal Regulations (CFR)**.

The **TRICARE Operations Manual (TOM)**, **TRICARE Reimbursement Manual (TRM)** and **TRICARE Policy Manual (TPM)** are regularly updated to reflect changes made to the CFR. Depending on the complexity of the law and federal funding, it can take a year or longer before the DOD provides direction for administering new policies.

**Note:** TRICARE-related statutes can be found in **Title 10, United States Code**, which houses all statutes regarding the Armed Forces. Unless otherwise specified, federal laws supersede state laws.

Refer to **DHA Manuals**, **www.tricare-west.com** and **TRICARE Provider News** for current information about policy changes, timelines and implementation guidance.

## *Health Insurance Portability and Accountability Act* of 1996

The *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) was enacted to combat waste, fraud and abuse; improve portability of health insurance coverage; and simplify health care administration.

### HIPAA 5010

HIPAA 5010 requires covered entities in the health care industry to implement and use mandated standards in the electronic transmission of health care transactions, such as claims, remittance advices, eligibility confirmations, and claims status requests and responses. Providers should contact their practice management system vendors or clearinghouses to ensure they support the HIPAA 5010 standard.

### HIPAA Transactions and Code Sets

The HIPAA Transactions and Code Sets Rule implements electronic standards for certain administrative and financial health care transactions. As required by the HIPAA Standard Transactions and Code Sets Rule, the Military Health System (MHS) and TRICARE apply HIPAA standards for electronic business functions. For more information, visit the **HIPAA and TRICARE Transaction & Code Sets** website. Figure 2.1 of this section lists mandated HIPAA electronic transactions. Network providers must utilize electronic data interchange (EDI) per their provider agreement. Non-network providers are encouraged to use EDI functions whenever possible for all transactions containing protected health information (PHI). Clear, legible and accurate data helps to reduce risk of a privacy incident.

### HIPAA Electronic Transactions Figure 2.1

| Transaction No. | Transaction Standard |
|---|---|
| X12N 270/271 | Eligibility/Benefit Inquiry and Response |
| X12N 278 | Referral Certification and Authorization |
| X12N 837 | Claims (Institutional, Professional and Dental) and Coordination of Benefits (COB) |
| X12N 276/277 | Claim Status Request and Response |
| X12N 835 | Claim Payment and Remittance Advice |
| X12N 834 | Enrollment/Disenrollment in a Health Plan |
| X12N 820 | Payroll Deduction for Insurance Premiums |
| NCPDP Telecom Std. Ver. 5.1 | Retail Pharmacy Drug Claims, COB, Referral Certification and Authorization, Eligibility Inquiry and Response |
| NCPDP Batch Std. Ver. 1.1 | Retail Pharmacy Drug Claims, COB, Referral Certification and Authorization, Eligibility Inquiry and Response |

## *HIPAA Privacy Rule*

As required by the *HIPAA Privacy Rule*, provider offices and groups must train all workforce members on policies and procedures related to PHI as necessary to carry out their functions. PHI is information in any format (electronic, paper, verbal) created or received by a provider, health plan or health care clearinghouse. PHI may contain information about a specific individual's past, present or future physical or mental health status; provision of health care; or payment for health care. The protected status of PHI continues for 50 years after the individual's death. PHI excludes such health information held in employment or educational records. Electronic PHI (ePHI) refers to PHI produced, saved, transferred, or received in an electronic format that is covered under HIPAA security regulations.

The following are examples of PHI (list is not all-inclusive):

- Home address
- Home telephone number
- Social Security number
- Medical records
- Photographs
- Dates of service
- Diagnosis and procedure codes
- Service types and/or descriptions
- Any information that may identify an individual and/or compromise the privacy of or prove harmful to the beneficiary (see **Title 45, CFR, Part 160, § 160.103** for PHI definition)

HIPAA requires all PHI to be kept confidential. Appropriate administrative, technical and physical safeguards must be in place to secure PHI (see **Title 45, CFR, Part 164, § 164.308** for administrative safeguards definition). Providers must reasonably safeguard PHI from intentional and unintentional use and disclosure that violates privacy standards, implementation specifications and other requirements. Some state laws are more stringent than HIPAA federal regulations. Providers must comply with both federal and state regulations.

The *HIPAA Privacy Rule* permits providers to use and disclose a patient's PHI for purposes of treatment, payment and health care operations. Additionally, providers do not need to obtain release or authorization to use PHI for health care operations activities such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance.

Under HIPAA, releases and authorizations are not required to disclose PHI:

- For treatment, payment and health care operations (**Title 45, CFR, Part 164, § 164.506**).
- To the individual.
- With a patient's written authorization.
- For public health activities.
- For health oversight activities.
- For specialized government functions, such as to national security or intelligence agencies.
- For law enforcement services.
- For judicial and administrative proceedings.
- To correctional institutions or law enforcement regarding inmates, as provided in **Title 45, CFR, Part 164, § 164.512(k)(5)**.

Refer to "***Release of Patient Information***" later in this section for more information.

## HIPAA Employer Identification Number

The National Employer Identifier Final Rule requires health care providers, plans and clearinghouses to accept and transmit employer identification numbers (EIN) in electronic health care transactions, when applicable. HIPAA defines employers as health insurance sponsors for their employees. The standard selected for the national employer identifier is the EIN issued by the Internal Revenue Service (IRS). The EIN appears on an employee's Internal Revenue Service (IRS) *Form W-2, Wage and Tax Statement* and is used to identify the employer in standard electronic health care transactions.

## *HIPAA National Provider Identifier Final Rule*

*The HIPAA National Provider Identifier Final Rule*, published in the CFR, establishes the National Provider Identifier (NPI) as the standard unique identifier for health care providers. An NPI is a 10-digit number used to identify a health care provider in all HIPAA standard electronic transactions. NPIs do not contain intelligence about providers. All entities defined as "health care providers" are eligible for NPIs. However, providers defined under HIPAA as "covered entities" are required to obtain and use NPIs. A covered entity is a provider, health plan or clearinghouse that conducts electronic health care transactions.

Health care provider NPI enumeration (assignment of NPIs to providers) and NPI-associated data maintenance are conducted through the **National Plan & Provider Enumeration System** (NPPES). The NPPES is the central system for identifying and uniquely enumerating health care providers at the national level. For enumeration purposes, there are two categories of health care providers. A Type 1 NPI is for individuals, such as physicians, nurses, dentists, chiropractors, pharmacists, and physical therapists. A Type 2 NPI is for organizations, such as hospitals and clinics (military and civilian), home health agencies, nursing homes, and laboratories. The NPI is meant to be a lasting identifier and is not replaced due to changes in a health care provider's name, address, ownership, health plan membership, or Healthcare Provider Taxonomy classification.

TRICARE providers should already have NPIs. If you do not have an NPI, complete the online NPPES application or download a paper application of the National Provider Identifier (NPI) Application/Update Form. You can also request an application from the NPI Enumerator in one of the following ways:

| | |
|---|---|
| **Phone** | 1-800-465-3203<br>1-800-692-2326 (TTY) |
| **Email** | **customerservice@npienumerator.com** |
| **Mail** | NPI Enumerator<br>PO Box 6059<br>Fargo, ND 58108-6059 |

For more information about NPIs, visit the **Centers for Medicare & Medicaid Services (CMS)** website. For TRICARE-specific information, visit TRICARE's website at **www.tricare.mil**.

### Military Health System Notice of Privacy Practices

The Military Health System (MHS) Notice of Privacy Practices informs beneficiaries about their rights regarding PHI, and it explains how PHI may be used or disclosed, who can access it and how it is protected. The notice is published in 11 languages.

Braille and audio versions are also available. Visit www.tricare.mil to download copies of the MHS Notice of Privacy Practices for you and your staff.

Privacy officers are located at every military hospital and clinic. They serve as beneficiary advocates for privacy issues and respond to beneficiary inquiries about PHI and privacy rights. More information about privacy practices and other HIPAA requirements is available on **www.tricare.mil**. Beneficiaries and providers also may email inquiries to **DHA.PrivacyAct@mail.mil**.

# TRICARE Provider Types

### TRICARE Provider Types, Figure 2.2

**TRICARE-Authorized Providers**

TRICARE-authorized providers must meet TRICARE licensing and certification requirements and be certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (laboratories and radiology providers), and pharmacies. TRICARE-authorized providers do not include pharmacists, naturopaths, chiropractors, kinesthesiologists, massage therapists, genetic counselors, or any other provider type not specifically named in **TRICARE Policy Manual (TPM)**, Chapter 11. Please refer to **TPM**, Chapter 11 for TRICARE-authorized provider requirements. Beneficiaries are responsible for the full cost of care if they see non-TRICARE–authorized providers.

There are two types of TRICARE-authorized providers: network and non-network.

**Network Providers**

- Regional contractors (for example, HNFS) have established networks, even in areas far from military hospitals or clinics.

TRICARE network providers:[1]

- Have signed agreements with HNFS.
- Agree to file claims and handle other paperwork for TRICARE beneficiaries.
- Must have professional liability insurance.

**Non-Network Providers**

- Non-network providers do not have signed agreements with HNFS and are, therefore, considered "out of network." TRICARE Prime beneficiaries must have authorization from HNFS to seek care from non-network providers.
- Providers may choose to participate on a case-by-case basis.
- There are two types of non-network providers: participating and nonparticipating:[2]

| Participating | Nonparticipating |
|---|---|
| • May choose to participate on a claim-by-claim basis.<br>• Agree to file claims for TRICARE beneficiaries, accept payment from TRICARE and accept the TRICARE-allowable charge as payment in full for their services. | • Do not agree to accept the TRICARE-allowable charge or file claims for TRICARE beneficiaries.<br>• Have the legal right to charge beneficiaries directly up to 15% above the TRICARE-allowable charge for services. |

[1] *TRICARE network providers have agreed to accept the TRICARE-allowable charge as payment in full for their services.*

[2] *When a TRICARE Prime beneficiary is referred to a nonparticipating, non-network provider, the provider can balance bill up to 115% of TRICARE Maximum Allowable Charge (TMAC). This means the beneficiary is responsible for up to 15% above the TMAC for the services rendered.*

# Accepting Patients From the U.S. Department of Veterans Affairs

Programs offered through the U.S. Department of Veterans Affairs (VA) are not TRICARE programs. They are unique health care programs administered by VA.

### VA Patients

TRICARE providers may be asked to accept requests from VA to provide care to veterans. VA (or administrators of specific VA programs) has the right to directly contact providers and request they provide care specifically to veterans on a case-by-case basis. 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. VA does not coordinate benefits with other government entities, including Medicare, Medicaid or TRICARE.

All VA facilities in the TRICARE West Region (West Region) are TRICARE providers and must function as any other TRICARE provider.

HNFS requires TRICARE network providers (individual, home health care, freestanding laboratories, and freestanding radiology only) who accept VA patients to accept assignment on these claims. For VA patient services, documentation and reimbursement for care will be coordinated between the referring VAMC and the TRICARE network provider.

All TRICARE network providers are listed in the **Network Provider Directory** as willing to receive VA patients based on availability. If you are a network provider and choose not to accept VA patients, you can update your information online using the Provider Demographics Update tool or through the **Network Provider Directory**.

Nothing prevents VA and the provider from establishing a direct contractual relationship if the parties so desire. A direct contractual relationship between a provider and VA takes precedence over the requirements of this section.

### Civilian Health and Medical Program of the Department of Veterans Affairs Patients

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a health care benefit that provides coverage to the spouse or widow(er) and children of eligible veterans.

HNFS reports network providers to CHAMPVA as TRICARE network providers. HNFS requires TRICARE network providers (individual, home health care, freestanding laboratories, and freestanding radiology only) who accept CHAMPVA patients to accept assignment with VA. These providers are listed in the **Network Provider Directory** as accepting CHAMPVA patients and accepting assignments on claims. If you are a TRICARE network provider and choose not to accept CHAMPVA patients, you can update your information online using the Provider Demographics Update tool or submitting an updated roster.

Find instructions on how to submit CHAMPVA claims at **www.va.gov**. Also refer to the *"**Claims Processing and Billing Information**"* section of this handbook for more information about submitting CHAMPVA claims.

## Military Hospitals and Clinics

A military hospital or clinic is usually located on or near a military installation. The TRICARE civilian provider network supplements military hospital and clinic resources and may work closely with military hospitals and clinics so that patients get the care they need. Military hospitals and clinics are listed in the **Network Provider Directory** as "military treatment facilities."

### Right of First Refusal

Military hospitals and clinic Commanders have the authority and responsibility to set priorities for enrollment to military primary care managers (PCMs) and have the right of first refusal (ROFR) concerning TRICARE Prime referrals for specialty appointments, inpatient admissions and procedures requiring a pre-authorization or referral. This means TRICARE Prime beneficiaries must first try to obtain care at a military hospital or clinic. Military hospital and clinic staff members review referrals to determine if they can provide care within access standards. If the service is not available within access standards, the beneficiary will be referred to a TRICARE network provider.

**Note:** The ROFR process does not apply to active duty service members (ADSM) or active duty family members (ADFM) enrolled in TRICARE Prime Remote.

## Urgent Care

TRICARE defines urgent care services as medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately but does require professional attention within 24 hours.

Examples of conditions that should receive urgent treatment include sprains, scrapes, earaches, sore throats, and a raised temperature – serious conditions, but not life-threatening. In many cases, a PCM or primary care provider can provide urgent care with a same-day appointment.

### Active Duty Service Members

Prior to seeking urgent care services, TRICARE Prime ADSMs must first contact their PCM so he/she can assess the level of care required and make arrangements to see the service member, schedule an appointment, or authorize TRICARE network provider urgent care services as appropriate. ADSMs enrolled in TRICARE Prime require a referral for all TRICARE network provider urgent care services; however, ADSMs enrolled in TRICARE Prime Remote do not require a referral due to their remote location.

TRICARE Prime's **point-of-service** option does not apply to ADSMs, who may be responsible for the entire cost of their care if they seek urgent care without a referral when required. (Refer to *"**Point-of-Service Option**"* in the ***TRICARE Eligibility*** section.)

### TRICARE Prime

TRICARE Prime beneficiaries (excluding ADSMs enrolled in TRICARE Prime) do not need a referral for urgent care and **point-of-service fees** will not apply when seeking urgent care from a network or non-network urgent care center or convenient care clinic (must be TRICARE authorized) or a network primary care provider type. Beneficiaries assigned to a military or TRICARE network PCM should seek all non-emergency follow-up care with their PCM.

Primary care provider types include:

- Family practice
- Internal medicine
- General practice
- Pediatrician
- Obstetrician/gynecologist
- Physician assistant
- Nurse practitioner
- Certified nurse midwife

Visit our **Network Provider Directory** to locate an urgent care provider near you.

### All Other Beneficiaries

All other beneficiaries enrolled in TRICARE Select, TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult (TRICARE Prime and TRICARE Select) do not require a referral or authorization prior to seeking any urgent care services from a network or non-network provider; however, out-of-pocket costs may be more when seeking services from non-network providers.

### Military Health System Nurse Advice Line

The MHS Nurse Advice Line provides eligible TRICARE beneficiaries with access to a team of registered nurses by telephone for advice about immediate health care needs. The MHS Nurse Advice Line is available 24 hours a day, seven days a week, by phone, web chat or video chat to beneficiaries who are anywhere in the world with a military hospital or clinic, including Guam, Puerto Rico, Cuba, South Korea, and Japan. Beneficiaries unable to reach their PCM or military hospital or clinic are encouraged to contact the MHS Nurse Advice Line for medical advice and assistance with same-day appointments.

**United States:**

Visit: **MHSNurseAdviceLine.com**

Dial: **1-800-TRICARE (1-800-874-2273)**, **option 1**

**Overseas:**

Visit **MHSNureAdviceLine.com** to find country-specific numbers.

## Emergency Care

TRICARE defines emergency conditions as those that threaten life, limb, sight, or safety. Emergency conditions include medical, maternity or psychiatric problems that would lead one to reasonably believe a situation exists that without medical help could lead to loss of life, limb or eyesight. An emergency also may include the need for immediate help to treat severe pain or relieve suffering.

Conditions that require emergency care include loss of consciousness, shortness of breath, chest pain, uncontrolled bleeding, sudden or unexpected weakness or paralysis, poisoning, suicide attempt, and drug overdose. This also includes pregnancy-related medical emergencies that involve sudden and unexpected medical complications that put the mother, the baby or both at risk. TRICARE does not consider a delivery after the 34th week an emergency.

**Note:** Care for accidental injury to the teeth alone or emergency room visits for dental pain are not covered by the TRICARE medical benefit.

If a beneficiary requires emergency care, direct him or her to call 911 or to go to the nearest emergency room.

## Corporate Services Provider Class

The Corporate Services Provider Class consists of institutional-based or freestanding corporations and foundations that provide professional, ambulatory or in-home care, as well as technical diagnostic procedures. Some of the specific provider types in this category include:

- Cardiac catheterization clinics
- Comprehensive outpatient rehabilitation facilities
- Diabetic self-management education programs (American Diabetes Association accreditation required)
- Freestanding bone marrow transplant centers
- Freestanding magnetic resonance imaging centers
- Freestanding sleep disorder diagnostic centers
- Home health agencies (pediatric or maternity management only)
- Home infusion
- Independent physiological laboratories
- Radiation therapy programs

Network Corporate Services Providers complete certification during the credentialing process. Non-network Corporate Services Providers must apply to become TRICARE authorized. Qualified non-network providers can download the application for TRICARE Provider Status/Corporate Services Provider at **www.tricare-west.com**.

**Note:** Claims must identify the provider who actually renders care (for example, physician, physician assistant, nurse practitioner) and the location where services were delivered.

Corporate Services Providers who deliver home health care are exempt from prospective payment system billing rules.

**Exception:** Home health agencies (HHA) that serve children under age 18 and/or pregnant women, even if they serve these populations exclusively, are not exempt from prospective payment system billing rules for home health care if they are Medicare certified.

For more information about Corporate Services Provider reimbursement, refer to **TPM**, Chapter 11, and the ***"Home Health Agency Pricing"*** paragraph of Section 8 in this handbook.

## Managing the Network

As the contractor for the West Region, HNFS is responsible for developing and maintaining an appropriately sized network of civilian providers to meet the demand of TRICARE beneficiaries. During the course of the contract, HNFS may determine there are a sufficient number of network providers to meet the demand in any given area and not offer an agreement to a provider interested in becoming a network provider. In the event you are not offered an agreement, HNFS encourages you to become a TRICARE-authorized non-network provider.

## Provider Certification and Credentialing

### TRICARE Certification – Becoming a Non-Network Provider

TRICARE only reimburses TRICARE-authorized providers. TRICARE-authorized providers must meet TRICARE licensing and certification standards and must comply with regulations specific to their health care areas.

Certified providers are considered non-network TRICARE-authorized providers unless they choose to join the TRICARE network. Non-network providers may also choose to accept assignment (that is, participate) on a case-by-case basis. If a non-network provider accepts assignment, he or she is considered a **participating non-network provider** and agrees to accept the TRICARE-allowable charge as payment in full for covered services and file claims for TRICARE beneficiaries.

**Nonparticipating non-network providers** do not have to accept the TRICARE-allowable charge or file claims for beneficiaries. However, nonparticipating non-network providers may not bill TRICARE beneficiaries more than 115% of the TRICARE-allowable charge.

**Note:** When a TRICARE Prime beneficiary is referred to a nonparticipating, non-network provider, the beneficiary is responsible for applicable copayments/cost-shares but not for a balance billing amount.

In many cases, providers can see TRICARE patients and file claims with TRICARE to initiate the certification process. However, some mental health care providers, certain non-Medicare–certified providers, skilled nursing facilities, and others must submit certification forms to our claims processing partner, PGBA, LLC (PGBA), prior to providing health care services. Download certification forms at **www.tricare-west.com**.

# Mental Health Care Providers

Freestanding partial hospitalization programs (PHP), intensive outpatient programs (IOP), residential treatment centers (RTC), opioid treatment programs (OTP), and substance use disorder rehabilitation facilities (SUDRF) must complete the HNFS contracting process if the facility wants to become a network provider.

**Exception:** This does not apply to VA health facilities.

Freestanding PHPs, IOPs, RTCs, OTPs, and SUDRFs must be TRICARE authorized and sign participation agreements to comply with all TRICARE policies prior to rendering services to TRICARE beneficiaries.

**Note for RTCs:** An RTC shall be currently accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (CoA), or an accrediting organization approved by the Director, Defense Health Agency (DHA). The RTC must be licensed to provide RTC services within the applicable jurisdiction in which it operates.

A TRICARE-authorized psychiatric PHP and IOP can be a distinct part of an otherwise TRICARE-authorized institutional provider or a freestanding program.

For TRICARE certification:

- **Acute care hospital-based PHPs and IOPs** – When a hospital is a TRICARE-authorized provider, the hospital's PHP and IOP also shall be considered a TRICARE-authorized provider.
- **Freestanding PHPs and IOPs** – Must currently be accredited by The TJC, CARF or the CoA.

## TRICARE Credentialing – Becoming a Network Provider

To join the West Region network, a TRICARE-authorized provider must complete the credentialing process and execute a network participation agreement with HNFS. The credentialing process requires verification of the provider's education, board certification, license, professional background, malpractice history, and other pertinent data.

A fully executed copy of the network participation agreement will be forwarded to the provider. HNFS will send credentialing approval separately from the fully executed network participation agreement.

Providers must complete both to be considered a network provider. HNFS monitors each network provider's quality of care and adherence to DOD, TRICARE and HNFS policies. Network providers must be recredentialed every three years.

**Exception:** HNFS does not credential VA providers.

For more information about becoming a network provider, visit our **Become a TRICARE Provider** page at **www.tricare-west.com** and refer to the *"**Health Care Management and Administration**"* section of this handbook.

Providers can check credentialing status online at **www.tricare-west.com**.

## Delegated Credentialing

If your provider group has a delegated credentialing agreement (delegation agreement) with HNFS, the delegate agrees to submit monthly changes (for example, new providers, terminations and demographic changes).

### *Roster Submission*

- Email completed rosters to **TRICAREwestdel@HNFS.com**.
- We recommend delegated groups to submit rosters using our **TRICARE Provider Roster** template, as it includes all the data elements required for referral, provider directory and claims payment purposes. If you are unable to use HNFS' group roster template, your delegated compliance auditor will work with you to make sure the rosters you submit have all the required elements. The roster template is available on the **Provider Forms** page at **www.tricare-west.com**.

### *Submission Frequency*

- HNFS recommends delegated groups send roster updates at a minimum of once a month.
- Per the Delegation Agreement, groups must submit full rosters within 10 days of their quarterly credentialing committee meetings.

### *Auditing*

To comply with recent URAC accreditation requirement changes, beginning Sept. 1, 2022, HNFS will conduct annual audits on delegated provider files. Previously, URAC required we conduct these audits once every three years.

## Applied Behavior Analysis Provider Types

Under TRICARE's Autism Care Demonstration (ACD), beneficiaries receive applied behavior analysis (ABA) services provided solely by authorized ABA supervisors defined as TRICARE-authorized Board Certified Behavior Analysts® (BCBA®s), Board Certified Behavior Analyst – Doctoral® (BCBA-D®s) or other qualified TRICARE-authorized independent providers with a scope of practice for independent (sole) practice of ABA® or under the ABA tiered-delivery model.

Under the tiered-delivery model, the authorized ABA supervisor is supported by:

- Board Certified Assistant Behavior Analyst® (BCaBA®),
- Qualified Autism Service Practitioner – Supervisor (QASP-S®)
- Licensed assistant behavior analyst (LABA), and/or
- Behavior technicians (BT), including:
  - Registered Behavior Technicians® (RBT®),
  - Applied Behavior Analysis Technicians (ABAT®),
  - Board Certified Autism Technicians (BCAT)
  - State-certified BT, where applicable

Assistant behavior analysts – defined as BCaBAs, QASP-Ss and LABAs – and BTs – defined as RBTs, ABATs and BCATs – work one-on-one with the beneficiary to implement the ABA treatment plan designed. Both assistant behavior analysts and BTs must be monitored and supervised by an authorized ABA supervisor.

An assistant behavior analyst and/or BT working within the scope of his or her training may assist the authorized ABA supervisor in various roles and responsibilities as determined appropriate by the authorized ABA supervisor with a scope of practice for independent practice of ABA. Assistant behavior analysts and BTs must work under the supervision of an authorized ABA supervisor.

**There are several states that offer an ABA license or certification. If your state offers an ABA license or certification, TRICARE requires you obtain the state-issued license or certificate from the state where the services are rendered.*

Where there is no ABA state-issued license or certification, certification may be provided by:

- Behavior Analyst Certification Board, Inc.® (BACB®) (BCBAs, BCBA-Ds, BCaBAs, RBTs)
- Qualified Applied Behavior Analysis Credentialing Board (QABA®) (ABATs, QASP-Ss)
- Behavioral Intervention Certification Council (BICC) (BCATs)

*Only authorized ABA supervisors may receive TRICARE reimbursement for ABA services. Assistant behavior analysts and/or BTs receive compensation from their ABA supervisor.*

### Applied Behavior Analysis Provider Requirements, Figure 2.3

| Applied Behavior Analysis Provider Requirements | | |
|---|---|---|
| **Provider Type** | **Certification** | **Requirement** |
| **All ABA Providers** | Basic Life Support (BLS) or Cardiopulmonary Resuscitation (CPR) Certification | **All ABA providers** must complete BLS or CPR-equivalent certification as demonstrated by completion of a live course or a hybrid course of a web-based instruction component and live component where participants demonstrate skills on a dummy. |
| **All ABA Providers** | Criminal History Background Check | HNFS collects copies of CHBCs from all ABA providers. CHBCs must include current federal, state and county criminal and sex offender reports for all locations resided or worked in during the previous 10 years.<br>**Note:** For sole ABA providers, HNFS runs the background checks. |
| **All ABA Providers** | National Provider Identifier (NPI) | All ABA providers must have an NPI. |
| **BTs**<br>(must be under the supervision of an authorized ABA supervisor) | BT Certification | BTs must be certified by one of the following in order to provide services as a TRICARE-authorized provider:<br>• BACB – RBTs,<br>• QABA – ABATs, QASP-Ss<br>• BICC – BCATs, or<br>• State certification (where applicable) |

Visit our **ABA Provider Types and Requirements** page to learn more.

# Value-Based Incentives

Value-based initiatives, as authorized by the National Defense Authorization Act for Fiscal Year 2016, seek to reward better health outcomes, enhance beneficiary experience of care and reduce health care costs over time.

# Network Provider Responsibilities

Network providers sign agreements with HNFS to comply with all TRICARE and HNFS regulations. **This handbook is not all-inclusive** and only provides an overview of TRICARE policies and procedures. Providers must have and maintain a current legal/agreement notice and general education email address and a HIPAA-compliant pre-authorization and referral fax

number. Providers must promptly notify HNFS of demographic updates (changes, additions, deletions) as they occur. Most demographic updates can be made using online tools at **www.tricare-west.com** or by submitting a roster using our TRICARE Provider Roster template (available on our **Forms** page). Find specific instructions for using the roster template at **www.tricare-west.com**. Failure to provide timely notification to HNFS may cause delays in receipt of claims payment.

As a reminder, network providers/groups agree to *(list is not all inclusive)*:

- Submit TRICARE claims electronically (except for applied behavior analysis providers, network providers in the state of Alaska are not required to submit claims electronically). HNFS strongly recommends signing up for electronic funds transfer (EFT) and electronic remittance advice (ERA) at **www.tricare-west.com** for faster payments and remits.
- Provide consultation reports, operative reports and/or discharge summaries – also known as patient encounter reports or clear and legible reports – to referring providers in a timely manner.
- Comply with pre-authorization and referral requirements and submit requests electronically.
- Not receive or accept, for any reason, reimbursement in excess of the TRICARE/CHAMPUS Maximum Allowable Charge (CMAC).
- Collect, at a minimum, copayment or cost-share at the time of service. The Explanation of Benefits (EOB) shall inform the provider and beneficiary of additional amounts owed to satisfy applicable deductibles.
- Maintain credentialing requirements for all providers within the group.

### Charging Administrative Fees

Network providers who have a signed agreement with HNFS may not charge beneficiaries administrative fees. Per the **TRICARE Operations Manual (TOM)**, Chapter 5, Section 1, network providers may only bill beneficiaries for applicable deductibles, copayments, and/or cost-sharing amounts; and they may not bill for charges that exceed contractually allowed payment rates, regardless of the beneficiary's TRICARE health plan coverage.

**Note:** Non-network participating providers who charge fees to beneficiaries for administrative expenses are not accepting TRICARE payment as payment in full, which is a violation of the conditions of their participation.

### Non-Discrimination Policy

All TRICARE-authorized providers agree not to discriminate against any TRICARE beneficiary on the basis of his or her participation in TRICARE, source of payment, sex, age, race, color, religion, national origin, health status, or disability. To access the full TRICARE policy, refer to the **TOM**, Chapter 1.

### Office and Appointment Access-to-Care Standards

TRICARE access-to-care standards ensure beneficiaries receive timely care within a reasonable distance from their homes. Emergency services must be available 24 hours a day, seven days a week. Network and military hospital and clinic providers must adhere to the following access standards for non-emergency care:

- **Urgent care or acute illness appointment** – Twenty-four hours
- **Routine care appointment** – One week (seven calendar days) and within 30 minutes (travel time) of the beneficiary's residence.

**Note:** A routine care appointment applies to a treatment request for a new health condition or exacerbation of a previously diagnosed condition for which intervention is required but not urgent.

- **Specialty care appointment** – Four weeks (28 calendar days) and within one hour (travel time) of the beneficiary's residence
- **Preventive care appointment** – Four weeks (28 calendar days)
- **Initial mental health care appointment with a mental health care provider** – One week (seven calendar days)

Office wait times for non-emergency care appointments should not exceed 30 minutes except when the provider's normal appointment schedule is interrupted due to an emergency.

If running behind schedule, notify the patient of the cause and anticipated length of the delay and offer to reschedule the appointment. The patient may choose to keep the scheduled appointment or reschedule for a future date or time.

## Canceled or Missed Appointments

TRICARE regulations do not prohibit providers from charging missed appointment fees. TRICARE providers are within their rights to enforce practice standards, as stipulated in the provider's policies and procedures, which require beneficiaries to sign agreements to accept financial responsibility for missed appointments. TRICARE does not reimburse beneficiaries for missed appointment fees. TRICARE providers may not submit claims to TRICARE for missed appointments.

### Primary Care Manager's Role

PCMs can be military or civilian TRICARE-authorized network or non-network providers assigned or selected to deliver non-emergency care to TRICARE Prime (TRICARE Prime, TRICARE Prime Remote [TPR], TRICARE Young Adult Prime [TYA]) beneficiaries. The following provider types may serve as TRICARE PCMs depending on state regulations and other factors:

- Certified nurse midwives
- Family practitioners
- General practitioners
- Internal medicine physicians
- Nurse practitioners
- Obstetricians/gynecologists
- Pediatricians
- Physician assistants

When enrolling in TRICARE Prime, beneficiaries select or are assigned a PCM. Whenever possible, a military PCM is assigned. Otherwise, a TRICARE network PCM is assigned or a non-network PCM for TPR beneficiaries. TRICARE Prime beneficiaries require a pre-authorization and/or referral to seek care from any provider other than their PCM, except in the following circumstances:

- If using the **point-of-service** option, which allows a TRICARE Prime beneficiary (non-ADSM) to receive non-emergency care without a referral from his or her PCM; however, when using this option, the beneficiary must pay a higher cost-share and a deductible.
- In an emergency.
- If seeking preventive services from a network provider in the beneficiary's region of enrollment.
- If seeking office-based outpatient mental health care and substance use disorder treatment services from a network provider in the beneficiary's region of enrollment.

**Note:** ADSMs need pre-authorization and/or referral for all non-emergency civilian care, including all mental health care services.

APCMs responsibilities include:

- Performing primary care services and managing all care.
- Rendering care for acute illness, minor accidents and follow-up care for ongoing medical problems as authorized in the TRICARE Prime benefits plans.
- Ensuring access to necessary health care services, as well as any specialty requirements, if the PCM cannot provide services.
- Providing access to care 24 hours a day, seven days a week, including after hours and urgent care or arranging for on-call coverage by another provider.

**Note:** The on-call provider must notify the PCM within 24 hours of an inpatient admission to ensure continuity of care.

- Determining the level of care needed:
  - **Urgent care:** Instructing the patient to contact the PCM's office on the next business day to schedule an appointment.
  - **Routine care:** Coordinating timely care for the patient.
- Referring patients for specialty care and obtaining pre-authorizations and referrals, when required, from HNFS.

**Note:** It is the provider's responsibility to verify and update demographic information, panel status and the ability to meet appointment and access-to-care standards. Providers can change information through the **Network Provider Directory** or the Provider Demographics Update tool (login required) at **www.tricare-west.com**.

## Specialty Care Responsibilities

TRICARE Prime beneficiaries require a referral from their PCM for most specialty care and may also require a referral from HNFS. The PCM and specialty care provider should coordinate with HNFS to obtain pre-authorizations and referrals. Network and non-network providers must follow TRICARE procedures and requirements for services that require pre-authorization or a referral. Per **TRICARE Reimbursement Manual (TRM)**, Chapter 1, network and non-network providers who submit claims for services without obtaining a pre-authorization when required will receive a 10% payment reduction during claims processing. For a network provider, the penalty may be greater than 10% depending on whether his or her network contract includes a higher penalty. Those payment penalties cannot be passed onto the beneficiary for payment. It is the provider's responsibility to obtain pre-authorization when required. Use the **Prior Authorization, Referral and Benefit Tool** to determine if a pre-authorization or referral is needed.

Specialty care referral requirements vary by TRICARE beneficiary type and TRICARE plan option.

### TRICARE Prime

- **ADSMs:** PCM and HNFS referrals are required for all civilian specialty care. Additionally, pre-authorization from HNFS is required for most services.

  **Note:** Ancillary services must be ordered by the PCM but are not considered specialty care.
- **ADFMs:** PCMs should refer patients to military hospitals or clinics or network providers whenever possible. ADFMs must obtain a PCM and HNFS referral for most care they receive from providers other than their PCMs or an on-call provider acting on behalf of their PCMs. This excludes preventive care, mental health care and substance use disorder treatment services from network providers, or when using the **point-of-service** option. Additionally, pre-authorization from HNFS is required for certain services.

### TRICARE Select

Beneficiaries may self-refer to TRICARE-authorized specialty care providers; however, pre-authorization from HNFS is required for certain services. Use the **Prior Authorization, Referral and Benefit Tool** to determine requirements. TRICARE Select beneficiaries who choose network providers may have a cost savings and an expanded preventive services benefit.

## Clear and Legible Reports/Consultation Reports

Whenever a military hospital or clinic refers a TRICARE beneficiary to a network provider, the network provider must provide consultation reports – also known as patient encounter reports or clear and legible reports (CLR). These include specialty care consultation/referral reports, operative reports, notes on the episode of care, and discharge summaries and must be submitted to the military hospital or clinic within the specified time frame listed below. The requirement to submit these reports applies to care referred by a military hospital or clinic and to care received at an urgent care center. Prompt submittal of consultation reports to the military hospital or clinic facilitates beneficiary care and is mandated by The Joint Commission accreditation requirements. The reports should contain a patient's identifying information, such as first name, middle

initial, last name; date of birth; and the last four digits of the sponsor's Social Security number. (As required by law, obtain beneficiary authorization when necessary before releasing sensitive information such as alcohol and drug abuse patient records.)

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

Submit reports within the following time frames:

- Urgent care centers: Submit within two (2) business days of delivering urgent care. The consultation reports must specify any referrals made during the urgent care visit.
- Other provider types (except mental health):
  - Submit within seven (7) business days of delivering care to a beneficiary.
  - For urgent and emergency situations, a preliminary report of a specialty consultation should be provided to the military hospital or clinic by telephone or by secure fax line within 24 hours of the urgent or emergent care (unless best medical practices dictate less time is required for a preliminary report).
  - Telephonic preliminary reports should be followed up with consultation reports sent to the local secure military hospital or clinic fax, including civilian provider referrals, within seven (7) business days 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.

Upon receipt of an approved pre-authorization or referral from HNFS, providers will receive a letter that contains a local secure military hospital or clinic fax number for submitting required reports to the military hospital or clinic. Network providers must follow the instructions included in the approval letter from HNFS.

HNFS requires network providers to fax all consultation reports directly to the secure fax number for the requesting military hospital or clinic. The **CLR Fax Matrix**, found on the **Clear and Legible Reports** page on the HNFS website, lists each military hospital's or clinic's secure fax number for providers to use. The **CLR Fax Matrix** is subject to change. Always confirm fax numbers before sending reports.

**Note:** The CLR secure fax number should not be used to fax pre-authorization and referral requests. For care referred by a civilian provider, follow your normal office protocol and forward consultation reports to the requesting provider within seven business days of the service or sooner if clinically appropriate. Submission of consultation reports to civilian providers is important as it ensures all treating providers are updated on the beneficiary's care.

## Emergency Care Responsibilities

TRICARE providers must notify HNFS of an emergency room inpatient admission within 24 hours, or by the next business day, by faxing the patient's hospital admission record face sheet to HNFS at **1-844-818-9289**. The hospital admission record face sheet should include the beneficiary's demographic information, health plan information, name of the admitting physician, admitting diagnosis and admission date. If the hospital admission record face sheet is not available, providers can also complete an **Inpatient TRICARE Service Request/ Notification** form and fax it to **1-844-818-9289**. Be sure to note on the form that the information is for an emergency inpatient admission notification.

HNFS reviews admission information and authorizes continued care if necessary. Refer to the ***"Medical Coverage"*** section in this handbook for more information on urgent care and emergency services.

## Balance Billing

A TRICARE network or participating non-network provider agrees to accept the TRICARE-allowable charge as payment in full for a covered service. These providers may not bill TRICARE beneficiaries more than this amount for covered services. Non-network, nonparticipating providers do not have to accept the TRICARE-allowable charge and may bill patients up to 15% above the TRICARE-allowable charge. If the billed amount is less than the TRICARE-allowable charge, TRICARE reimburses the billed amount.

**Note:** When a TRICARE Prime beneficiary is referred to a nonparticipating, non-network provider, the beneficiary is only responsible for the copayment amount, not for any balance billing amount.

If a TRICARE beneficiary has other health insurance (OHI), the provider should bill the OHI first. After the OHI pays, TRICARE pays the remaining billed amount up to the TRICARE-allowable charge for covered services. Providers may not collect more than the billed charge from the OHI (the primary payer), and TRICARE combined. OHI and TRICARE payments may not exceed the beneficiary's liability.

TRICARE uses Medicare's billing limitations. Non-compliance with balance billing requirements may affect a provider's TRICARE and/or Medicare status. Balance billing limitations only apply to TRICARE-covered services. Providers may not bill beneficiaries for administrative expenses, including collection fees, to collect TRICARE payment.

Additionally, network providers cannot bill beneficiaries for non-covered services unless the beneficiary agrees in advance and in writing to pay for these services. Refer to ***"Informing Beneficiaries about Non-Covered Services"*** below and ***"Hold Harmless Policy"*** in this section for more information.

For more information about balance billing, visit the **Balance Billing** page at **www.tricare-west.com**.

## Informing Beneficiaries About Non-Covered Services and TRICARE's Hold Harmless Policy

Before delivering care, network providers must notify TRICARE patients if services are not covered. The beneficiary must agree in advance and in writing to receive and accept financial responsibility for non-covered services. The agreement must

document the specific services, dates, estimated costs, and other information.

It is imperative network providers use the **Request for Non-Covered Services** form available on the HNFS website or equivalent documentation (such as a statement or letter written, dated and signed by the beneficiary prior to receipt of services) to satisfy these requirements. A general agreement to pay, such as one signed by the beneficiary at the time of admission, is not sufficient to prove that a beneficiary was properly informed or agreed to pay. Notes demonstrating the beneficiary has been fully informed in advance of receiving the services, the services are excluded or excludable and the beneficiary has agreed to pay for them must be documented in writing in the patient's file.

If the beneficiary does not sign a **Request for Non-Covered Services** form or equivalent, the provider is financially responsible for the cost of non-covered services delivered. Network providers should keep copies of the **Request for Non-Covered Services** form or equivalent in their offices.

Refer to the ***Medical Coverage*** section of this handbook for a summary of TRICARE-covered and non-covered services and benefits.

## Hold Harmless Policy

A network provider may not bill a TRICARE beneficiary for excluded or excludable services (that is, the beneficiary is held harmless), except in the following circumstances:

- The beneficiary did not inform the provider that he or she was a TRICARE beneficiary.
- The beneficiary was informed that services were excluded or excludable and agreed in advance and in writing to pay for services.

Providers should be aware there have been incidents when a TRICARE beneficiary has agreed to pay in full for non-covered services without signing a valid waiver. The provider rendered the care in good faith without pre-authorization, and the beneficiary was not held responsible for payment. Without a signed waiver, the provider was denied reimbursement and could not bill the beneficiary. To find out more about TRICARE's Hold Harmless Policy, please refer to the **TOM**, Chapter 5.

**Note:** Non-network providers should also inform beneficiaries in advance if services are not covered. Although not required, HNFS strongly encourages non-network providers to use a **Request for Non-Covered Services** form.

## Release of Patient Information

If a beneficiary (including an eligible child) requests patient information, the reply should be addressed to the beneficiary and not his or her custodial parent or guardian. The only exceptions are:

- When a parent/guardian writes on behalf of a minor child (under 18 years of age).
- When a parent/guardian writes on behalf of a mentally or physically disabled beneficiary.

Per the **TOM**, Chapter 1, Section 19, providers are prohibited from charging administrative service fees for furnishing medical records.

Per the **TOM**, Chapter 7, Section 1, HNFS cannot disclose information about the following services to parents or guardians of any beneficiaries, including minors and mentally or physically disabled beneficiaries:

- Human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS)
- Alcoholism
- Abortion
- Substance abuse
- Venereal disease

TRICARE-eligible beneficiaries must maintain a "signature on file" in their providers' office to protect patient privacy, release important information and prevent fraud. A new signature is required for each admission for claims submitted on a UB-04 claim form, but only once each year for professional claims submitted on a 1500 Health Insurance Claim Form (1500). Claims for diagnostic tests, test interpretations and certain other services do not require the beneficiary's signature. Providers submitting these claims must indicate "patient not present" on the claim form.

Mentally or physically disabled TRICARE beneficiaries aged 18 years or older who are incapable of providing signatures may have legal guardians appointed or powers of attorney issued on their behalf. This legal documentation must include the guardian's signature, full name, address, relationship to the patient, and the reason the patient is unable to sign. The first claim a provider submits on behalf of the beneficiary should include the legal documentation establishing the guardian's signature authority. Subsequent claims may be stamped with "Signature on File" in the beneficiary signature box of the 1500 or UB-04 claim form.

If the beneficiary does not have legal representation, the provider must submit a written report with the claim to describe the patient's illness or degree of mental disability and should annotate in Box 12 of the 1500 claim form, "Patient's or Authorized Person's Signature—Unable to Sign."

- If the beneficiary's illness was temporary, the signature waiver must specify the dates the illness began and ended.
- If a beneficiary is mentally competent but physically incapable of providing a signature, a representative may be issued a general or limited power of attorney by signing an "X" in the presence of a notary representative.

## Release of Medical Records

HNFS representatives must comply with HIPAA guidelines when TRICARE beneficiaries or their personal representatives call regarding claims and other patient-specific information. If information is requested on behalf of someone else, HNFS cannot disclose information until a HIPAA-compliant **Authorization to Disclose Health Information** form or the appropriate legal paperwork is received (for example, powers of attorney, guardianship, divorce/custody agreements).

Without the appropriate documents, HNFS will not disclose information to a person who:

- Calls on behalf of a spouse or adult child, aged 18 years or older (aged 21 years or older in Nebraska).
- Is the guardian (other than a parent) of a minor child.
- Is the spouse of a deployed ADSM.
- Was never married to his or her child's TRICARE sponsor.

If you have additional questions about the HIPAA and TRICARE, visit the **TRICARE** and **U.S. Department of Health and Human Services** websites.

### Dismissing a TRICARE Beneficiary From Your Care

Every practice should have a policy in place regarding how and when a patient should be discharged from care. TRICARE policy does not detail when it is appropriate to dismiss a beneficiary. However, suddenly refusing to see a beneficiary again, even one with whom the physician has had serious problems in the past, can be seen as patient abandonment and could lead to legal liability.

In rare circumstances, you may have a need to dismiss a TRICARE beneficiary from your care. You must provide written notification of the dismissal to the TRICARE beneficiary. You must offer 30 days of transitional care and/or referrals for urgent needs from the date of the dismissal letter. A copy of the written notification should be kept on file in the event of any confusion concerning the dismissal.

## Updating Provider Information

The **Network Provider Directory**, located at **www.tricare-west.com**, helps beneficiaries and other providers find TRICARE network providers. Network providers are required to promptly notify HNFS of demographic updates (changes, additions, deletions) as they occur. This helps ensure beneficiaries seeking health care services and providers seeking to refer care are viewing the most current and accurate provider information. Keeping your information up to date also ensures that HNFS sends payments to your correct address and helps everyone avoid inadvertent disclosures of patients' PHI.

Network providers should visit the online **Network Provider Directory** to confirm their individual listings and statuses are accurate. Most demographic updates can be made using online tools at **www.tricare-west.com** or by submitting a provider roster using the TRICARE Provider Roster template (available on our **Forms** page).

Find specific instructions at **www.tricare-west.com**. If you are a network provider and do not see your practice listed in the **Network Provider Directory**, contact the HNFS Customer Service line at **1-844-866-WEST (1-844-866-9378)** to inquire about being listed.

Keep in mind:

- Certain specialties may be credentialed by HNFS at the individual level but only listed in the **Network Provider Directory** at the group level.
- HNFS must credential all network nurse practitioners and physician assistants, but only those identified as PCMs will display in the **Network Provider Directory**.
- Individual assistant behavior analysts are not displayed in the **Network Provider Directory**.
- Individual ABA BTs are not displayed in the **Network Provider Directory**. BTs updating their specialty to BCBA, BCaBA, BCBA-D, QASP-S must go through the credentialing process to request changes.

If your group has a delegated credentialing agreement, refer to the *"**Delegated Provider information**"* in Section 6 of this handbook. The **Network Provider Directory** does not include non-network providers. The online **Non-Network Provider Directory** offers non-network doctors, hospitals and other health care professionals in the West Region.

Non-network providers are encouraged to verify and update their demographic information at **www.tricare-west.com** or by faxing updated information to **1-844-730-1373**.

For additional information, see *"**Online Network Provider Directory**"* in the *Welcome to TRICARE section*.

## Beneficiary Rights and Responsibilities

TRICARE beneficiaries have the right to:

**Get information** – Beneficiaries have the right to receive accurate, easy-to-understand information from written materials, presentations and TRICARE representatives to help them make informed decisions about TRICARE programs, medical professionals and facilities.

**Choose providers and plans** – Beneficiaries have the right to a choice of health care providers that is sufficient to ensure access to appropriate, high-quality health care.

**Emergency care** – Beneficiaries have the right to access emergency health care services when and where the need arises.

**Participate in treatment** – Beneficiaries have the right to receive and review information about the diagnosis, treatment and progress of their condition, and to fully participate in all decisions related to their health care, or to be represented by family members, conservators or other duly appointed representatives.

**Respect and nondiscrimination** – Beneficiaries have the right to receive considerate, respectful care from all members of the health care system without discrimination based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

**Confidentiality of health information** – Beneficiaries have the right to communicate with health care providers in confidence and to have the confidentiality of their health care information

protected as required by law. They also have the right to review, copy and request amendments to their medical records.

**Complaints and appeals** – Beneficiaries have the right to a fair and efficient process for resolving differences with their health plans, health care providers and the institutions that serve them.

For more information about beneficiary rights, visit **www.tricare.mil**.

TRICARE beneficiaries have the responsibility to:

**Maximize health** – Beneficiaries have the responsibility to maximize healthy habits, such as exercising, not smoking and maintaining a healthy diet.

**Make smart health care decisions** – Beneficiaries have the responsibility to be involved in health care decisions, which means working with providers to develop and carry out agreed-upon treatment plans, disclosing relevant information and clearly communicating wants and needs.

**Be knowledgeable about TRICARE** – Beneficiaries have the responsibility to be knowledgeable about TRICARE coverage and program options.

TRICARE beneficiaries also have the responsibility to:

- Show respect for other patients and health care workers.
- Make a good-faith effort to meet financial obligations.
- Use the disputed claims process when there is a disagreement.
- Report wrongdoing and fraud to appropriate resources or legal authorities.
- Pay copayments, cost-shares and deductibles.
- Pay for non-covered services (if the beneficiary agreed in advance and in writing to pay for the non-covered services).
- Pay all charges if ineligible for TRICARE at the time of service.

ADFMs enrolled in TRICARE Prime plans do not have copayments, cost-shares or deductibles, except for:

- Pharmacy copayments
- **Point-of-service** cost-shares and deductibles
- Extended Care Health Option (ECHO) cost-shares

TRICARE beneficiaries cannot be billed for the following charges:

- The difference between the billed amount and negotiated rate
- Denied claims
- Claims requiring adjustments
- Claims not yet processed
- Amounts above the diagnosis-related group (DRG) reimbursement schedule for DRG hospitals
- Amounts in excess of the negotiated or contracted per diem

## An Important Message From TRICARE

Inpatient facilities are required to provide each TRICARE beneficiary with a copy of the document, **An Important Message From TRICARE**. This document details the beneficiary's rights and obligations upon admission to the hospital. The signed document must be kept in the beneficiary's file. A new document must be provided for each admission.

# TRICARE Eligibility

## TRICARE Eligibility

TRICARE is available worldwide to eligible beneficiaries, including active duty service members (ADSMs) and their families, retired service members and their families, National Guard and Reserve members and their families, survivors, certain former spouses and others, from any of the eight uniformed services – the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Space Force, U.S. Coast Guard, the U.S. Public Health Service, and the National Oceanic and Atmospheric Administration. All beneficiaries must register in the Defense Enrollment Eligibility Reporting System (DEERS) to be eligible for TRICARE.

## Verifying Eligibility

Providers must verify TRICARE eligibility at the time of service. Identification (ID) cards are a part of the verification process for determining a TRICARE beneficiary's eligibility and plan option coverage. Providers should ensure beneficiaries have valid Common Access Cards (CACs), uniformed services identification (USID) cards or eligibility authorization letters. Read descriptions of these items below. Check the expiration dates on CACs and USIDs and make copies of both sides of the cards for your files. Refer to "***Copying ID Cards***" later in this section for additional information.

TRICARE provides enrollment cards, referred to as wallet cards, for enrollment-based plans. Refer to "**Enrollment Cards**" later in this section.

A CAC or USID alone does not prove TRICARE eligibility. All eligibility is based on DEERS. Beneficiaries can verify their eligibility in DEERS by calling **1-800-538-9552**. Providers must verify the beneficiary's TRICARE eligibility online through **www.tricare-west.com** or through the automated phone menu options at **1-844-866-WEST (1-844-866-9378)**. Use the sponsor's Social Security number (SSN) or Department of Defense (DOD) Benefits Number (DBN) to verify eligibility. If you are verifying online, retain a printout of the eligibility verification screen for your files.

Newborns and adopted children are considered a qualifying life event (QLE) and must be registered in DEERS within 90 days of birth, adoption or court appointment or DEERS will show "loss of eligibility." After this time period, newborns and adopted children will no longer be able to receive TRICARE benefits until registered in DEERS. Some TRICARE programs require enrollment. This is separate from registration in DEERS. For information on verifying eligibility for newborns, visit **www.tricare-west.com**.

### Common Access Card

Active duty armed forces, selected reserves, National Guard, National Oceanic and Atmospheric Administration, U.S. Public Health Service, and U.S. Coast Guard members carry CACs. Before providing care, check the CAC expiration date. Although CACs are valid uniformed services ID cards, they do not, on their own, prove TRICARE eligibility. Providers must verify patient eligibility as described earlier in this section.

### Uniformed Services Identification Card

The USID, like the CAC, incorporates a digital photographic image of the bearer. It also has barcodes containing pertinent machine-readable data and printed ID and entitlement information.

USIDs include the following information:

- **Expiration date** – Check the expiration date (should read "INDEF" for retirees). If expired, the beneficiary must immediately update his or her information in DEERS and get a new card.
- **Civilian** – Check the back of the ID card to verify eligibility for TRICARE civilian care. The center section should read "YES" under the box titled "Civilian."

A TRICARE For Life (TFL) beneficiary with an ID card that reads "NO" in this block may still use TFL only if he or she has both Medicare Part A and Part B coverage.

A beneficiary's valid photo ID presented with a copy of the sponsor's activation orders (when activated for more than 30 consecutive days) may serve as proof of the patient's TRICARE eligibility. Because beneficiaries under age 10 are usually not issued ID cards, the parent's proof of eligibility may serve as proof of eligibility for the child.

## Enrollment Cards

TRICARE beneficiaries enrolled in one of the following plans are issued wallet cards:

- TRICARE Prime
- TRICARE Prime Remote (TPR)
- TPR for Active Duty Family Members
- TRICARE Select
- TRICARE Young Adult (TYA)
- TRICARE Retired Reserve (TRR)
- TRICARE Reserve Select (TRS)

Wallet cards are not mailed to beneficiaries; instead, beneficiaries may view and print cards through the Defense Manpower Data Center's **milConnect website**.

While wallet cards do not guarantee eligibility and are not required to obtain care, they do contain important information for beneficiaries and providers.

## Department of Defense Benefits Number

To protect personally identifiable information, SSNs are not printed on new DOD ID cards.

DOD ID cards contain the following identifiers:

- **DOD ID Number** – A 10-digit number that is not used for TRICARE claims, eligibility, or authorization and referral purposes.
- **DBN** – An 11-digit number that relates to TRICARE benefit eligibility. This number is located on the back of the card at the top, next to the date of birth.

Providers may use either **DBNs** or SSNs for identification purposes. Providers may still ask a TRICARE beneficiary for his or her sponsor's SSN, verbally or in writing, as required by individual office protocol.

## Identification Cards for Family Members Aged 75 Years and Older

All eligible family members and survivors aged 75 years or older receive permanent ID cards. These ID cards should read "INDEF" in the box titled "Expiration Date." If expired, the beneficiary must immediately update his or her information in DEERS and get a new card.

## Copying Identification Cards

To prevent identity theft and protect information from individuals impersonating U.S. military personnel, TRICARE advises beneficiaries not to lose or allow others to use their CACs or USIDs. However, it is legal and advisable for providers to copy CACs and USIDs for authorized purposes, which may include:*

- Facilitating medical care eligibility determination and documentation
- Cashing checks
- Verifying TRICARE eligibility
- Administering other military-related benefits

The DOD recommends providers retain photocopies of both sides of CACs and USIDs for future reference.

**Title 18, United States Code, Section 701 prohibits photographing or possessing uniformed services ID cards in an unauthorized manner. Unauthorized use would exist if the bearer uses the card in a manner that would enable him or her to obtain benefits, privileges or access to which he or she is not entitled.*

## Sponsor Eligibility and Out-of-Pocket Costs

With respect to beneficiary cost-sharing, the National Defense Authorization Act of 2017 (NDAA FY 2017) introduced a split of beneficiaries into two groups: one group (grandfathered beneficiaries) consists of sponsors and their family members who first became affiliated with the military through enlistment or appointment before Jan. 1, 2018, and the second group (non-grandfathered beneficiaries) who first became affiliated on or after that date. As such, for services performed on or after Jan. 1, 2018, the sponsor's enlistment date affects how much a beneficiary will pay for out-of-pocket costs (cost-shares, copayments, deductibles, etc.). Please refer to **www.tricare-west.com** and the **TRICARE Reimbursement Manual (TRM)** to verify a patient's out-of-pocket responsibility.

**Note:** TFL beneficiaries will continue to have their cost-sharing requirements calculated for services received on or after Jan. 1, 2018, as if TRICARE Standard and Extra were still being carried out by the DOD.

## Important Notes About Eligibility

**Active Duty Service Members and Family Members**

ADFMs lose TRICARE eligibility at midnight on the day the active duty sponsor separates from service, unless they are eligible for **Transitional Assistance Management Program (TAMP)** coverage or the sponsor is transitioning to a retired status.

ADSMs must enroll in TRICARE Prime or TPR. Once a member's eligibility is verified, care may be delivered and billed to TRICARE for payment. The service branch usually provides care for ADSMs at a military hospital or clinic and pays for required civilian emergency or referred health care. ADSM claims must be submitted to HNFS for processing. Refer to the "***Claims Processing and Billing Information***" section of this handbook for additional details.

**National Guard and Reserve: Line of Duty**

Reserve component members who become ill or injured, or aggravate a medical condition while on active duty, are entitled to medical care coverage under TRICARE for that specific medical condition only. This eligibility is referred to as line of duty (LOD), also known as notice of eligibility (NOE) for Coast Guard members.

LOD care is only authorized for the acquired injury or illness; however, the beneficiary may not show as TRICARE-eligible in DEERS. LOD eligibility is a branch of service responsibility and is initiated through the beneficiary's unit medical representative, not HNFS or DEERS. Refer to "***TRICARE for the* National Guard and Reserve**" later in this section for additional details.

## Spouses

Spouses, including same-sex spouses, of service members (active duty, retired or National Guard and Reserve) are eligible for TRICARE.

## TRICARE and Medicare Eligibility

TRICARE beneficiaries who are eligible for premium-free Medicare Part A must also have Part B to remain TRICARE eligible. Beneficiaries are automatically eligible under TRICARE For Life (TFL), TRICARE's Medicare wraparound coverage, when they have Medicare Part A and Part B coverage. TRICARE benefits will be discontinued for any period of time during which a beneficiary only has Medicare Part A.

**Exceptions –** The following beneficiaries may delay Medicare Part B enrollment and keep their TRICARE benefits:

- ADFMs eligible for premium-free Medicare Part A do not need Medicare Part B to keep their TRICARE benefits. However, once sponsors retire from active duty, all sponsors and family members eligible for premium-free Medicare Part A must also have Medicare Part B to keep their TRICARE benefits.
- TRS, TRICARE Retire Reserve (TRR), Continued Health Care Benefit Program (CHCBP), and US Family Health Plan (USFHP) beneficiaries, who are eligible for premium-free Medicare Part A, are not required to purchase Medicare Part B to remain covered under TRICARE benefits.

**Note:** TRICARE covers ADSMs, regardless of Medicare eligibility. Medicare eligibility may continue up to eight and a half years beyond the date that Social Security disability benefits end. However, beneficiaries must continue to purchase Medicare Part B after disability benefits end to keep TRICARE coverage. For more information about TFL, refer to "***TRICARE For Life***" later in this section.

## Eligibility for TRICARE and Veterans Affairs Benefits

In some cases, beneficiaries are eligible for benefits under TRICARE and the U.S. Department of Veterans Affairs (VA). If a TRICARE beneficiary is also eligible for health care through VA, he or she has the option to use either TRICARE or VA benefits. Furthermore, TRICARE allows such beneficiaries to receive medically necessary care for the same episode of care, even if they have already been treated by VA. Please note, service-connected care is covered by VA only.

**Note:** Eligibility for health care through VA for a service-connected disability is not considered dual coverage.

## TRICARE Health Care Program Options

TRICARE offers comprehensive medical and mental health benefits to all TRICARE beneficiaries. It is important to be aware of the TRICARE program plan options available according to beneficiary category.

## TRICARE Prime Coverage Options

TRICARE Prime and TRICARE Prime Remote (TPR) are managed care options offering the most affordable and comprehensive coverage. While ADSMs must enroll in TRICARE Prime or TPR, ADFMs and retirees and their families, and others may choose to enroll in a TRICARE Prime or TRICARE Select option.

When on active duty orders for more than 30 consecutive days, National Guard and Reserve members are covered as ADSMs and must enroll in TRICARE Prime or TPR. During activation, their eligible family members are covered as ADFMs and may enroll in TRICARE Prime, TPR or TRICARE Select.

**Note:** National Guard on pre-activation orders are not required to enroll in TRICARE Prime or TPR.

### TRICARE Prime

TRICARE Prime is a health maintenance organization (HMO)-like program with an annual enrollment requirement. It generally features use of military hospitals and clinics and substantially reduced out-of-pocket costs for authorized care provided by civilian providers. Beneficiaries generally agree to use military facilities and designated civilian provider networks and to follow certain managed care rules and procedures. Beneficiaries who enroll in TRICARE Prime are assigned or select a primary care manager (PCM). A PCM is a provider of primary care, who furnishes or arranges for all health care services required by the Prime enrollee. TRICARE Prime is available in TRICARE Prime Service Areas (PSAs).

TRICARE Prime beneficiaries should always seek non-emergency care from their PCMs, unless using the **point-of-service** option. (**Note: Point-of-service** is not available to ADSMs.) In most cases, TRICARE Prime beneficiaries must obtain a referral from their PCMs and HNFS to receive non-emergency care from another provider.

This excludes preventive care and outpatient mental health care and substance use disorder treatment services from network providers.

### TRICARE Prime Remote

TPR, including TPR for ADFMs, offers TRICARE Prime coverage for ADSMs in remote locations and the family members who live with them. ADSMs and their families, who live and work more than 50 miles or a one-hour drive time from the nearest military hospital or clinic, may be eligible to enroll in TPR. Each TPR beneficiary is assigned or may select a PCM. Whenever possible, a network civilian PCM will be assigned, but a non-network PCM may be assigned if a network provider is not available.

TRICARE Prime beneficiaries, excluding ADSMs enrolled in Prime, do not need a referral for urgent care and the **point-of-service** option will not apply when seeking urgent care from a network or non-network urgent care center or a network primary care type provider. ADSMs enrolled in TRICARE Prime still require referrals for urgent care; however, ADSMs enrolled in TPR do not require referrals due to their remote location. Beneficiaries assigned to a military or civilian PCM should seek all non-emergency follow-up care with their PCM.

TPR beneficiaries without assigned PCMs should contact the provider acting as their PCM, or they may call HNFS at **1-844-866-WEST (1-844-866-9378)** to coordinate their specialty care. TPR ADSMs may also require approval from the Defense Health Agency-Great Lakes (DHA-GL) Specified Authorization Staff (SAS) for non-emergency care. The SAS determines referral management for ADSM fitness-for-duty care.

To determine if a particular ZIP code falls within a TPR coverage area, use the **TRICARE Prime Remote ZIP Code Locator**.

## TRICARE Prime and TRICARE Prime Remote Primary Care Managers

PCMs coordinate all care for their TRICARE Prime and TPR beneficiaries and provide non-emergency care whenever possible. The PCM also maintains patient medical records and provides referrals for specialty care that he or she cannot provide. When required, PCMs work with HNFS to obtain pre-authorizations and referrals. Refer to the *"**Health Care Management and Administration**"* section of this handbook for more information about pre-authorization and referral requirements.

PCMs can be military or civilian TRICARE-authorized network or non-network providers assigned or selected to deliver non-emergency care to TRICARE Prime or TPR beneficiaries. The following provider types may serve as TRICARE PCMs depending on state regulations and other factors:

- Certified nurse midwives
- Family practitioners
- General practitioners
- Internal medicine physicians
- Nurse practitioners
- Obstetricians/gynecologists
- Pediatricians
- Physician assistants

It is important PCMs are aware of referral end dates and advise beneficiaries when additional referrals are required. Refer to the *"**Important Provider Information**"* section of this handbook for more information about PCM roles and responsibilities.

## TRICARE Prime and TRICARE Prime Remote Point-of-Service Option

The **point-of-service** option allows TRICARE Prime and TPR (non-ADSMs), and TYA Prime beneficiaries to obtain medically necessary TRICARE-covered services from any TRICARE-authorized provider (network or non-network), other than their PCM, without first obtaining a referral.

**Note:** TPR beneficiaries without an assigned PCM should contact the provider acting as their PCM, or they may call HNFS at **1-844-866-WEST (1-844-866-9378)** to coordinate their specialty care.

The **point-of-service** option is applied when:

- A TRICARE Prime, TPR or TYA Prime beneficiary receives care from a network or non-network TRICARE-authorized provider without a referral from his or her PCM.
- A TRICARE Prime, TPR or TYA Prime beneficiary self-refers to a civilian specialty care provider after a referral has been authorized by HNFS to a military hospital or clinic specialty care provider.
- A TRICARE Prime, TPR or TYA Prime beneficiary self-refers to a non-network specialty care provider after a referral has been authorized by HNFS to a network specialty care provider.

**Point-of-service** does not apply in the following circumstances:

- ADSM care (ADSMs who do not coordinate care through their PCM may be responsible for the entire cost of care)
- Emergency services
- Urgent care services from a network or non-network urgent care center or a network primary care type provider
- Preventive care services from a network provider in the beneficiary's region of enrollment
- Outpatient mental health care and substance use disorder treatment services from a network provider in the beneficiary's region of enrollment
- Beneficiaries whose other health insurance (OHI) is primary
- Newborn or adoptee care (a newborn or adoptee is covered as a TRICARE Prime/TPR ADFM beneficiary for the first 90 days after birth or adoption, as long as one additional family member is enrolled in TRICARE Prime/TPR ADFM or the sponsor is active duty)
- Ancillary services (for example, diagnostic radiology and ultrasound services, diagnostic nuclear medicine services, pathology and laboratory services, and cardiovascular studies)

When using the **point-of-service** option, beneficiaries will pay a deductible and 50% of the TRICARE-allowable charge. **Point-of-service** costs do not apply to the catastrophic cap. The **point-of-service** option does not affect provider reimbursement. For **point-of-service** cost information, visit **www.tricare-west.com**.

**Note:** ADSMs cannot use the **point-of-service** option and must obtain pre-authorizations and referrals for civilian care. If an ADSM receives care without a pre-authorization or referral, DHA-GL/SAS must review the claim for payment determination. If DHA-GL/SAS approves the care, the ADSM does not have to pay the bill. If DHA-GL/SAS does not approve, the ADSM is responsible for the entire cost of care.

# TRICARE Select

**TRICARE Select** is a self-managed, preferred provider organization (PPO) program with an annual enrollment requirement. It allows beneficiaries to use the TRICARE civilian provider network, with reduced out-of-pocket costs compared to care from non-network providers, as well as military facilities (where they exist and when space is available). A major feature of TRICARE Select is that enrollees do not have restrictions on their freedom of choice with respect to health care providers. TRICARE Select beneficiaries realize cost savings and expanded preventive services benefits when they use network providers.

TRICARE Select beneficiaries do not have PCMs and may self-refer to TRICARE-authorized providers. However, certain services require pre-authorization from HNFS. Refer to the *"Health Care Management and Administration"* section of this handbook for more information about pre-authorization requirements.

# TRICARE Young Adult

**TRICARE Young Adult (TYA)** offers TRICARE Prime or TRICARE Select coverage depending on which option the beneficiary chooses. TYA options are premium-based plans that require enrollment and are available to young adult children of eligible uniformed services sponsors and those under age 26 who aged out of TRICARE at age 21 (or age 23 if a full-time college student). To be eligible for TYA, young adult children otherwise eligible cannot be married, a member of the uniformed services, qualified for an employer-sponsored health plan, or eligible for other TRICARE coverage. Additional information about TYA can be found at **www.tricare-west.com**.

# Direct-Care Only

TRICARE-eligible beneficiaries who do not enroll in a TRICARE plan are only eligible to receive care at a military hospital or clinic on a space-available basis.

# TRICARE For Life

**TRICARE For Life (TFL)** is a Medicare-wraparound coverage available to all Medicare-eligible TRICARE beneficiaries, regardless of age or place of residence, provided they have Medicare Parts A and B. TFL beneficiaries are considered dual-eligible for Medicare and TRICARE. TFL beneficiaries have the freedom to seek care from Medicare-certified providers, at military hospitals and clinics on a space-available basis or at VA facilities (if eligible).

Some beneficiaries entitled to premium-free Medicare Part A, including ADFMs, TRS, TRR, CHCBP, and USFHP beneficiaries may keep their current TRICARE benefits without Medicare Part B coverage. Medicare allows certain beneficiaries to sign up for Medicare Part B during a special enrollment period, which waives monthly Part B late-enrollment premium surcharges. However, all beneficiaries are strongly encouraged to sign up for Medicare Part B as soon as they become eligible in order to avoid a break in TRICARE coverage and incurring monthly Medicare late enrollment premium surcharges.

TFL beneficiaries must present a valid (USID) card and a Medicare card prior to receiving services. If a TFL beneficiary's USID reads "NO" under the box titled CIVILIAN, he or she is still eligible to use TFL if he or she has both Medicare Part A and Part B. Copy both sides of the cards and retain the copies for your files.

There is no separate TFL enrollment card. To verify TFL eligibility, call the TFL contractor, Wisconsin Physicians Service – Military and Veterans Health (WPS) at **1-866-773-0404**. You may call the Social Security Administration at **1-800-772-1213** to confirm a patient's Medicare status.

**Note:** Beneficiaries aged 65 years and older who are not eligible for premium-free Medicare Part A may remain eligible for TRICARE Prime or TRICARE Select. Refer to *"TRICARE and Medicare Eligibility"* in the *"TRICARE Eligibility"* section of this handbook for more information. Parents and parents-in-law are not eligible for TFL.

## How TRICARE For Life Works

TFL and dual-eligible beneficiaries do not require pre-authorizations or referrals from HNFS for health care services. These beneficiaries should follow Medicare rules for services requiring pre-authorization. However, there are certain procedures that require pre-authorization when TRICARE is the primary payer.

- For services covered by both TRICARE and Medicare, Medicare pays first and TRICARE pays its share of the remaining expenses second (unless the beneficiary has OHI).
- For services covered by TRICARE but not by Medicare, TRICARE processes the claim as the primary payer. The beneficiary is responsible for the applicable TFL deductible and cost-share.
- For services covered by Medicare but not by TRICARE, Medicare is the primary payer and TRICARE pays nothing. The beneficiary is responsible for the applicable Medicare deductible and cost-share.
- For services not covered by Medicare or TRICARE, the beneficiary is responsible for the entire bill.

Refer to the *"Claims Processing and Billing Information"* section of this handbook for information about TFL claims and coordinating with OHI. For more information about TFL, visit the WPS website at **www.tricare4u.com** or call **1-866-773-0404**. If you have questions regarding Medicare benefits and coverage, contact Medicare at **1-800-MEDICARE (1-800-633-4227)**.

# TRICARE for the National Guard and Reserve

National Guard and Reserve components include:

- Air Force Reserve
- Air and Space Force National Guard
- Army National Guard
- Army Reserve
- Marine Corps Reserve
- Navy Reserve
- U.S. Coast Guard Reserve

## Line of Duty Care for National Guard and Reserve Members

A **line of duty (LOD)** condition is determined by the military service and includes any injury, illness or disease incurred or aggravated while the National Guard or Reserve member is in a duty status, either inactive duty (such as reserve drill) or active duty. This includes the time period when the military service member is traveling directly to or from the location where he or she performs military duty.

LOD care is only authorized for the acquired injury or illness; however, the beneficiary may not be listed as TRICARE-eligible in DEERS. LOD eligibility is a branch of service responsibility and is initiated through the beneficiary's unit medical representative, not HNFS or DEERS. LOD-eligible members will receive a written authorization that specifies the LOD condition and terms of coverage. Coast Guard members receive a notice of eligibility (NOE). It is the beneficiary's responsibility to ensure the LOD documentation is on file at either a military hospital or clinic or Defense Health Agency (DHA)-Great Lakes (DHA-GL), and that DHA-GL authorizes all follow-up care.

LOD coverage is separate from transitional health care coverage under the Transitional Assistance Management Program (TAMP), Transitional Care for Service-Related Conditions (TCSRC) program or coverage under TRS.

Whenever possible, military hospitals and clinics provide care to National Guard and Reserve members with LOD conditions. Military hospitals or clinics may refer National Guard and Reserve members to civilian TRICARE providers. If there is no military hospital or clinic nearby to deliver or coordinate care, DHA-GL may coordinate non-emergency care with any TRICARE-authorized network provider.

The provider should submit medical claims directly to HNFS unless otherwise specified on the LOD-written authorization or requested by the National Guard or Reserve member's Medical Department Representative. HNFS forwards DHA-GL any claim not referred by a military hospital or clinic or pre-approved by DHA-GL for DHA-GL to approve or deny.

**Note:** TRICARE-authorized providers should not reach out to the military hospital/clinic or DHA-GL for additional information on authorizations. Instead, contact HNFS for assistance.

***Coverage When Activated for More Than 30 Consecutive Days***

When called to active duty for more than 30 consecutive days, National Guard and Reserve members are considered ADSMs and must enroll in TRICARE Prime or TPR.

Family members of National Guard and Reserve members also may become eligible for TRICARE if the National Guard or Reserve member (sponsor) is called to active duty for more than 30 consecutive days. These family members may enroll in TRICARE Prime or TPR, depending on location, or TRICARE Select. They also are eligible for dental coverage through the TRICARE Dental Program. Sponsors must register their family members in DEERS to establish TRICARE eligibility.

## TRICARE Reserve Select and TRICARE Retired Reserve

TRICARE Reserve Select (TRS) is a premium-based health plan offered by the DOD to qualified members of the Selected Reserve of the Ready Reserve. TRICARE Retired Reserve (TRR) is a premium-based health plan offered by the DOD to eligible members of the Retired Reserve. TRS and TRR offer comprehensive health care coverage and have patient cost-shares, copayments and deductibles similar to TRICARE Select, but beneficiaries must pay monthly premiums. These beneficiaries may self-refer to any TRICARE-authorized provider; however, certain services (for example, inpatient admissions for substance use disorders and mental health, adjunctive dental care, home health services) require pre-authorization from HNFS.

Refer to the *"Health Care Management and Administration"* section of this handbook for more information about pre-authorization requirements.

**Note:** Eligible young adults of sponsors who have TRS or TRR coverage can enroll in TRICARE Young Adult (TYA) Select. Those members in the Individual Ready Reserve, including Navy Reserve Voluntary Training Units, do not qualify to purchase TRS.

# TRICARE Pharmacy Program

TRICARE offers comprehensive prescription drug coverage and several options for filling prescriptions. All TRICARE beneficiaries are eligible for the TRICARE Pharmacy Program administered by Express Scripts, Inc. (Express Scripts). To fill prescriptions, beneficiaries need written prescriptions/e-prescriptions and valid (USID) cards or CACs.

TRICARE beneficiaries have the following options for filling prescriptions:

- **Military pharmacies** – Using a military pharmacy is the least expensive option, but formularies may vary by pharmacy. Contact the local military pharmacy to check availability before prescribing a medication. Civilian providers can send prescriptions electronically to military pharmacies. Check your e-prescribing software application for the military pharmacy nearest you. Most military pharmacies' electronic pharmacy names begin with "DOD."

  Non-formulary drugs may only be filled at a military pharmacy if a military provider prescribed the drug or if the beneficiary was referred out by the military hospital or clinic.

Some military pharmacies accept e-prescriptions for controlled substances.

- **TRICARE Pharmacy Home Delivery** – The TRICARE Pharmacy Home Delivery mail order option is the preferred method when not using a military pharmacy, especially for beneficiaries using maintenance medications.
- **TRICARE retail network pharmacies** – Beneficiaries can access a large network of retail pharmacies in the United States and certain U.S. territories (Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).
- **Non-network retail pharmacies** – Filling prescriptions at a non-network retail pharmacy is the most expensive option and is not recommended for beneficiaries.

As outlined in the **TRICARE Pharmacy Program Handbook**, drug categories include:

- **Generic formulary drugs.** These drugs are widely available. Beneficiaries have the lowest out-of-pocket costs for these drugs.
- **Brand-name formulary drugs.** These drugs are generally available. Plus, they offer the second lowest copayment.
- **Non-formulary drugs.** These drugs may have limited availability. Beneficiaries have higher copayments for these drugs. Also, there's generally an alternative formulary drug available. It's often more cost effective, and equally or more clinically effective.
- **Non-covered drugs.** TRICARE doesn't cover these drugs. If beneficiaries choose to purchase a non-covered drug, they'll pay 100% of the drug's cost. These drugs are either not as clinically effective or cost effective as other drugs offered. They may also pose a significant safety risk that may outweigh any potential clinical benefit.

Per law, all TRICARE beneficiaries, except ADSMs, are required* to get select brand-name maintenance medications through either TRICARE Pharmacy Home Delivery or from a military pharmacy. Beneficiaries who choose to keep using retail pharmacies for these select brand-name maintenance medications will pay full cost. TRICARE will allow two courtesy refills at retail pharmacies. Beneficiaries who continue to refill affected medications at retail pharmacies must then pay the full cost of the medication. View the Select Maintenance Drug List at **www.health.mil/selectdruglist**.

For more information about benefits and costs, visit the **TRICARE** or **Express Scripts** websites or call Express Scripts at **1-877-363-1303**.

**This does not apply to generic medications or to medications taken for acute conditions. Beneficiaries living overseas or who have OHI with prescription drug coverage are not affected.*

## TRICARE Pharmacy Home Delivery

TRICARE offers a mail order prescription program called TRICARE Pharmacy Home Delivery, which is managed by Express Scripts, Inc. Prescriptions by mail order are the least expensive option for TRICARE beneficiaries when they are not using a military pharmacy. Home delivery is best suited for medication taken on a regular basis. Providers may prescribe up to a 90-day supply of medications.

New prescriptions can be faxed (with a fax cover sheet) directly to Express Scripts at **1-877-895-1900**. Faxed prescriptions must contain the following information in order to be processed: patient's full name, date of birth, address, and sponsor's SSN or DBN. Only prescriptions faxed directly from a provider's office will be accepted.

Prescriptions for Schedule II controlled substances cannot be faxed (they must be mailed). Visit the **Express Scripts** website or call **Express Scripts** at **1-877-363-1303** for more information.



## Member Choice Center

The Member Choice Center helps TRICARE beneficiaries transfer their current retail and military pharmacy maintenance medication prescriptions to mail order by telephone. If one of your patients uses the Member Choice Center, an Express Scripts patient-care advocate may contact you for patient and prescription information.

To learn more about the Member Choice Center, call **Express Scripts** at **1-877-363-1303** or access information online by visiting the **TRICARE** or **Express Scripts** websites.

## Quantity Limits

TRICARE has established quantity limits for certain medications, which means the DOD pays up to a specified amount of medication each time the beneficiary fills a prescription. Quantity limits help ensure medications are safely and appropriately used. Exceptions to established quantity limits may be made if the prescribing provider is able to justify medical necessity. Use the **TRICARE Formulary Search Tool** for a list of TRICARE-covered prescription drugs that have quantity limits.

## Pre-Authorizations for Medications

Some medications require pre-authorization from Express Scripts. Medications requiring pre-authorization may include, but not be limited to, prescription drugs specified by the DOD Pharmacy & Therapeutics Committee, brand-name medications with generic equivalents, medications with age limitations, home infusion/injections, and medications prescribed for quantities exceeding normal limits.

Use the **TRICARE Formulary Search Tool** for a list of TRICARE-covered prescription drugs that require pre-authorization. Providers also can locate pre-authorization and medical necessity criteria forms for retail network and mail order prescriptions. Military pharmacies may follow different procedures. At the top of each form, there is information on where to send the completed form. For assistance, call **1-877-363-1303** or the Pharmacy Pre-Authorization line at **1-866-684-4488**.

## Generic Drug Use Policy

It is DOD policy to use generic medications instead of brand-name medications whenever possible. A brand-name drug with a generic equivalent may be dispensed only after the prescribing physician completes a clinical assessment that indicates the brand-name drug is medically necessary and after Express Scripts grants approval. If your patient requires a brand-name medication that has a generic equivalent, you must obtain pre-authorization. Otherwise, the patient may be responsible for the entire cost of the medication. If a generic-equivalent drug does not exist, the brand-name drug is dispensed at the brand-name cost.

## Uniform Formulary Drugs and Non-Formulary Drugs

The DOD has established a uniform formulary, which is a list of covered generic and brand-name drugs. The formulary also contains a third tier of medications that are designated as non-formulary. The DOD Pharmacy & Therapeutics Committee may recommend to the Director of DHA that certain drugs be placed in the third, non-formulary tier. These medications include any drug in a therapeutic class determined not to be as clinically effective or as cost effective as other drugs in the same class.

For an additional cost, third-tier drugs are available through TRICARE Pharmacy Home Delivery or retail network pharmacies. A beneficiary may be able to fill a non-formulary prescription at formulary costs if the provider can establish medical necessity for the non-formulary medication by completing and submitting the appropriate **TRICARE Pharmacy Medical Necessity** form to Express Scripts for the non-formulary medication.

- **ADSMs** – If medical necessity is approved, ADSMs may receive non-formulary medications through TRICARE Pharmacy Home Delivery or retail network pharmacies at no cost.
- **All other eligible beneficiaries** – If medical necessity is approved, the beneficiary may receive the non-formulary medication at the formulary cost through TRICARE Pharmacy Home Delivery or retail network pharmacies.

**Note:** Non-formulary drugs may only be filled at a military pharmacy if a military provider prescribed the drug or if the beneficiary was referred out by the military hospital or clinic.

For medical necessity to be established, at least one of the following criteria must be met for each available formulary alternative:

- Use of the formulary alternative is contraindicated.
- The patient experiences, or is likely to experience, significant adverse effects from the formulary alternative, and the patient is reasonably expected to tolerate the non-formulary medication.
- The formulary alternative results in therapeutic failure, and the patient is reasonably expected to respond to the non-formulary medication.
- The patient previously responded to a non-formulary medication and changing to a formulary alternative would incur unacceptable clinical risk.

Call **Express Scripts** at **1-877-363-1303** or visit the **www.tricare.mil/medicalnecessity** website for forms and medical necessity criteria. To learn more about medications and common drug interactions, check for generic equivalents, or to determine if a drug is classified as a non-formulary medication, use the **TRICARE Formulary Search Tool**.

## Step Therapy Medication

Step therapy involves prescribing a safe, clinically effective and cost-effective medication as the first step in treating a medical condition. The preferred medication is often a generic medication that offers the best overall value in terms of safety, effectiveness and cost. Non-preferred drugs are only prescribed if the preferred medication is ineffective or poorly tolerated.

Drugs subject to step therapy will only be approved for first-time users after they have tried one of the preferred agents on the DOD Uniform Formulary (for example, a patient must try omeprazole or Nexium® prior to using any other proton pump inhibitor).

**Note:** If a beneficiary filled a prescription for a step therapy drug within 180 days prior to step therapy implementation, the beneficiary will not be affected by step therapy requirements and will not be required to switch medications.

For a complete list of medications subject to step therapy, use the **TRICARE Formulary Search Tool**.

# Prescription Monitoring Program

TRICARE's Prescription Monitoring Program (PMP) helps identify patients who may need assistance due to a higher use of controlled substances. The PMP also includes a review of prescribing providers to help identify and prevent unnecessary prescribing or over-prescribing of controlled substances, such as opioids. Under this program, Express Scripts, Inc., DHA and the regional TRICARE contractors perform a quarterly review of all beneficiaries who were prescribed controlled substances and the providers who prescribed them under the TRICARE benefit. HNFS then uses this information to determine any education and outreach needed.

## Provider Follow Up

HNFS medical directors will review prescribing practices based on industry best practices and clinical practice guidelines. Providers who fall outside of what are considered normal prescribing patterns may be contacted by HNFS.

Examples of additional support provided:

- Education to include TRICARE covered benefits that may complement treatment, such as substance use disorder and mental health treatment, alternative pain-related treatments; and
- Training for programs such as national and state Prescription Drug Monitoring Programs (PDMP) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

The Centers for Disease Control and Prevention (CDC) has written the **Guideline for Prescribing Opioids for Chronic Pain** to assist providers with determining the appropriate time to introduce and ways to manage opioids for the treatment of pain.

Use the **PMP web tool** (login required) to determine if TRICARE patients have any prescription restrictions. Find additional information at **www.militaryrx.express-scripts.com** and our **Pharmacy Benefits A–Z** page.

## Compound Medications

By TRICARE regulation, and in alignment with Medicare Part D policy, the TRICARE Pharmacy Program does not cover compound medications containing ingredients not approved by the U.S. Food and Drug Administration (FDA).

Express Scripts can identify compound medications containing non-FDA approved ingredients and will apply its standard prescription screen to the individual ingredients in compound prescriptions to ensure they are safe, effective and covered by TRICARE. If a compound does not pass an initial screen, the pharmacist can switch a non-approved ingredient with an approved one or request a new prescription from the provider. If this is not possible, providers may ask Express Scripts to consider other evidence by requesting a pre-authorization. TRICARE will continue to reimburse claims for compound medications containing FDA-approved ingredients.

## Pharmacy Options for Medicare-Eligible Beneficiaries

Medicare-eligible beneficiaries can use TRICARE Pharmacy Program benefits. However, TRICARE beneficiaries who turned 65 on or after April 1, 2001, must also enroll in Medicare Part B. If they choose not to enroll, their pharmacy benefit will be limited to the medications available at military pharmacies.*

Medicare-eligible beneficiaries also are eligible for Medicare Part D prescription drug plans. However, they do not need to enroll in a Medicare Part D prescription drug plan to keep their TRICARE benefit. You can direct your patients to visit TRICARE's **Medicare-Eligible Beneficiaries** page for additional details.

For the most current information about Medicare Part D, call Medicare at **1-800-Medicare (1-800-633-4227)** or visit the **Medicare** website.

**Exceptions exist for certain beneficiaries, including ADSMs and ADFMs. Refer to **TRICARE For Life** earlier in this section for more information.*

## Pharmacy Data Transaction Service

The Pharmacy Data Transaction Service (PDTS) is a centralized data repository that records information about DOD beneficiaries' prescriptions. The PDTS allows providers to access complete patient medication histories, helping increase patient safety by reducing the likelihood of adverse drug-drug interactions, therapeutic overlaps and duplicate treatments.

The PDTS conducts an online prospective drug utilization review (a clinical screening) in real time against a beneficiary's complete medication history for each new or refilled prescription before it is dispensed to the patient. Regardless of where a beneficiary fills a prescription, prescription information is stored in a robust central data repository and is available to authorized PDTS providers, including military hospital and clinic pharmacies and providers; TRICARE retail network pharmacies; and TRICARE Pharmacy Home Delivery.

## Specialty Medication Care Management

Specialty medications are usually high-cost, self-administered, injectable, oral or infused drugs that treat serious chronic conditions (for example, multiple sclerosis, rheumatoid arthritis, hepatitis C). These drugs typically require special storage and handling and are not readily available at local pharmacies.

Specialty medications also may have side effects that require pharmacist and/or nurse monitoring. The Specialty Medication Care Management (SMCM) program is structured to improve the health of beneficiaries through continuous health evaluation, ongoing monitoring and assessment of educational needs and management of medication use.

This voluntary program provides:

- Access to proactive, clinically based services for specific diseases designed to help beneficiaries get the most benefit from their medications.
- Monthly refill reminder calls.
- Scheduled deliveries to beneficiaries' specified locations.
- Specialty consultations with nurses or pharmacists at any point during therapy.

These services are provided to beneficiaries at no additional cost when they receive their medications through TRICARE Pharmacy Home Delivery. If you or your patient order a specialty medication through TRICARE Pharmacy Home Delivery, Express Scripts sends the patient additional information about the SMCM program and how to get started.

Beneficiaries enrolled in the SMCM program may contact pharmacists 24 hours a day, seven days a week. The specialty clinical team reaches out to the beneficiary's physicians, as needed, to address beneficiary's issues, such as side effects or

disease exacerbations. If any of your patients currently fill specialty medication prescriptions at retail pharmacies, the specialty clinical team will provide brochures detailing the program as well as pre-populated enrollment forms. If a patient requires specialty pharmacy medications, you may fax the prescription to Express Scripts at **1-877-895-1900**.Express Scripts ships medications to the beneficiary's home. Faxed prescriptions must include the following identifying information: patient's full name, date of birth, address, and ID number.

**Note:** Some specialty medications may not be available through TRICARE Pharmacy Home Delivery because the manufacturer limits the drug's distribution to specific pharmacies. If you submit a prescription for a limited-distribution medication, Express Scripts either forwards the prescription to a pharmacy of the patient's choice that can fill it or provides the patient with instructions about where to send the prescription.

To determine if a specialty medication is available through TRICARE Pharmacy Home Delivery, use the **TRICARE Formulary Search Tool**. Specialty drugs not available through Express Scripts require pre-authorization and may be ordered through **Accredo's** website.

# TRICARE Dental Options

The TRICARE health care benefit covers adjunctive dental care (dental care that is medically necessary to treat a covered medical condition). However, several non-adjunctive dental care options are available to eligible beneficiaries. ADSMs receive dental care at military dental clinics or from network providers through the TRICARE Active Duty Dental Program (ADDP), if necessary. For all other beneficiaries, TRICARE offers the TRICARE Dental Program (TDP) and dental plan options through the Federal Employees Dental and Vision Insurance Program (FEDVIP). Visit **www.tricare.mil/dental** for more information.

**Note:** TRICARE may cover some medically necessary services in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental or physical disabilities and children ages five years and younger. Refer to the "***Medical Coverage***" section of this handbook for more details.

## TRICARE Active Duty Dental Program

The ADDP is administered by United Concordia Companies, Inc. and provides civilian dental care to ADSMs who are referred for care by a military dental clinic or who serve and reside more than 50 miles from a military dental clinic.

## TRICARE Dental Program

The TDP is a voluntary dental insurance program available to eligible ADFMs and National Guard and Reserve and Individual Ready Reserve members and their eligible family members.

The TDP is administered by United Concordia Companies, Inc. ADSMs (and National Guard and Reserve members called to active duty for a period of more than 30 consecutive days or eligible for the pre-activation benefit up to 90 days prior to their report date) are not eligible for the TDP. They receive dental care at military dental clinics or through the ADDP.

## Federal Employees Dental and Vision Insurance Program

The FEDVIP is a voluntary dental and vision insurance program offered by the U.S. Office of Personnel Management (OPM). Open enrollment season occurs each fall, beginning the Monday of the second full week in November to the Monday of the second full week in December. TRICARE beneficiaries are not automatically enrolled in FEDVIP. FEDVIP offers comprehensive, cost-effective dental and vision coverage for uniformed services retirees and their eligible family members, retired National Guard and Reserve members (including those who are entitled to retired pay but will not begin receiving it until age 60) and their eligible family members, certain surviving family members of deceased active duty sponsors and Medal of Honor recipients and their immediate family members and survivors. Visit **www.tricare.benefeds.com** for more information.

# Cancer Clinical Trials

There are three types of covered National Cancer Institute (NCI)-sponsored cancer clinical trials for eligible beneficiaries:

- **Phase I** – Study the safety of an agent or intervention for the prevention, screening, early detection, and treatment of cancer.
- **Phase II** – Study the safety and effectiveness of an agent or intervention on a particular type of cancer and evaluate how it affects the human body.
- **Phase III** – Compare a promising new treatment against the standard approach. These studies also focus on a particular type of cancer.

## Trial Costs

TRICARE cost-shares all medical care and testing required to determine eligibility for an NCI-sponsored trial. All medical care required to participate in a trial is processed under normal reimbursement rules (subject to the TRICARE-allowable charge), provided each of these conditions is met:

- The provider seeking treatment for a TRICARE-eligible beneficiary in an NCI-approved protocol obtained pre-authorization for the proposed treatment before initial evaluation.
- The treatments are NCI-sponsored Phase I, Phase II or Phase III protocols.
- The patient continues to meet entry criteria for the protocol.
- The institutional and individual providers are TRICARE authorized.

## Trial Participation

Participation in NCI clinical trials requires pre-authorization. Visit the NCI website for a list of some, but not all, of the Phase I, II and III NCI-sponsored cancer clinical trials. You must contact the TRICARE West Region Cancer Clinical Trials Coordinator at **1-855-722-5837** before beginning evaluation or treatment as part of a clinical trial.

# Extended Care Health Option

The Extended Care Health Option (ECHO) provides financial assistance to eligible ADFMs for specific mental or physical disabilities and offers beneficiaries an integrated set of services and supplies beyond those included in the basic TRICARE programs (for example, TRICARE Prime, TPR, TRICARE Select). Potential ECHO beneficiaries must be ADFMs, have qualifying conditions and be registered to receive ECHO benefits.

Conditions qualifying an ADFM for TRICARE ECHO coverage include, but are not limited to:

- Moderate-to-severe mental retardation
- A severe physical disability
- A severe physical or psychological condition that results in the beneficiary's homebound status
- Two or more disabilities affecting separate body systems such that one disability alone is not an ECHO-qualifying condition (for example, a beneficiary with a combination of a mild hearing and vision impairment)

Active duty sponsors with family members seeking ECHO registration must enroll in their service's Exceptional Family Member Program (EFMP) – unless waived (specific situations only). Refer patients to TRICARE's **ECHO** web page for information about eligibility and ECHO registration. Providers may be requested to provide medical records, such as progress notes, or assist beneficiaries with completing EFMP documents.

Beneficiaries must be registered to be eligible for ECHO benefits. There is no retroactive registration for the ECHO program. Visit our **ECHO** page for more information.

## ECHO Provider Responsibilities

TRICARE providers, especially primary care managers (PCM), are responsible for managing care for TRICARE beneficiaries. Any TRICARE provider (PCM or specialist) can inform the patient's sponsor about ECHO benefits.

Providers must obtain pre-authorization for all ECHO services. Network providers must submit ECHO claims on the patient's behalf. Participating non-network providers may file claims on the patient's behalf or the patient may pay out-of-pocket and file their own paper claim for reimbursement.

## ECHO Benefits

ECHO provides coverage for the following services and supplies:

- Medical and rehabilitative services not specifically covered under the basic TRICARE benefit.
- Training, including how to use assistive technology devices such as a specialized computer keyboards.
- Hippotherapy for those beneficiaries with a primary or secondary diagnosis of cerebral palsy or multiple sclerosis.
- Incontinence supplies or diapers that support skin integrity and prevent deterioration of skin due to incontinence may be covered for beneficiaries aged three years and older who are incontinent from spinal, neurologic and/or mobility issues.
- Vocational support such as classes that teach a beneficiary to become more independent with life skills.
- Family training to assist in the management of the beneficiary's qualifying condition – for example, training a family member to use the ECHO beneficiary's specialized equipment and alternative communication methods.
- Institutional care when the severity of the qualifying condition requires protective custody or training in a residential environment.
- Private transportation to and from an ECHO-authorized service for institutionalized ECHO beneficiaries – for example, mileage reimbursement to transport the institutionalized ECHO beneficiary to and from an ECHO-authorized service.
- Assistive services, such as those from a qualified interpreter or translator for beneficiaries who are deaf – for example, readers for the blind and sign language interpreters to assist in receiving ECHO-authorized services.
- Durable equipment – for example, feeding chair or specialized stroller.
- Durable equipment adaptation and maintenance tray or assistive technology device.
- Respite care – up to 16 hours of care.

## ECHO Home Health Care Benefits

The ECHO Home Health Care (EHHC) benefit provides medically necessary skilled services or respite care to those ECHO beneficiaries who are homebound and generally require more than 28 to 35 hours per week of home health services.

- Skilled nursing services – The EHHC skilled nursing benefit provides services from a licensed nurse such as a licensed vocational nurse/licensed practical nurse or registered nurse. Under this benefit, the services the beneficiary needs are skilled. The number of hours the beneficiary may be eligible for is based on their level of skilled needs and the EHHC benefit cap. The suctioning of a tracheotomy tube is an example of skilled nursing care.
- Respite care – The EHHC respite care benefit provides a maximum of eight hours per day up to five days per week to give primary caregivers time to sleep. This respite care is for the caregivers of those beneficiaries who need frequent skilled interventions – three or more times in the eight-hour respite period. For example, an approved respite provider might be suctioning the mouth or giving medication or formula through a feeding tube three or more times during the respite period.

**Note:** Only one of the respite care benefits (ECHO respite or EHHC respite) can be used in the same calendar month – they both cannot be used during the same calendar month.

Providers are required to attest the homebound status for any beneficiaries requiring in-home care under the ECHO benefit. This includes in-home skilled hourly nursing care and EHHC respite care services. Please use the **EHHC attestation** form available at **www.tricare-west.com**.

## Extended Care Health Option Costs and Catastrophic Cap Information

TRICARE ECHO beneficiaries have a monthly cost-share based on the sponsor's pay grade during the months services are used. The sponsor/beneficiary is responsible for the monthly cost-share plus any amount exceeding the government's maximum coverage. The cost-share applies only once per month, not per service. If there is more than one family member receiving ECHO services, only one cost-share is required.

The monthly cost-share is paid directly to the ECHO-authorized provider. The cost-share under ECHO is in addition to out-of-pocket costs incurred for services and items received through the TRICARE Prime, TPR and TRICARE Select options. Cost-shares under ECHO do not accrue to the catastrophic cap or deductible. The maximum government cost-share is $36,000 per calendar year per beneficiary for benefits under the ECHO program. The EHHC skilled services and EHHC respite benefits are not included in these cap amounts. Coverage for the EHHC skilled services and EHHC respite care benefits are capped on a fiscal year basis.

For more information about TRICARE ECHO, visit our **ECHO** page or refer to the **TRICARE Policy Manual (TPM)**, Chapter 9.

## Autism Care Demonstration

Applied behavior analysis (ABA) services under TRICARE are covered under the Autism Care Demonstration (ACD). ADFMs must register for ECHO to participate in the ACD.

**Note:** To qualify for ECHO, beneficiaries also must be enrolled in the EFMP through the sponsor's branch of service.

For more information, visit our **Autism Care Demonstration** pages. Also refer to the *"Covered Services"* section of this handbook.

# Supplemental Health Care Program

The Supplemental Health Care Program (SHCP) provides coverage by civilian health care providers to ADSMs and designated non-TRICARE–eligible patients. Although pre-authorizations and claims processing are administered by the TRICARE contractors (for example, HNFS), it is funded separately by the DOD and follows different rules than TRICARE.

The following individuals are eligible for the SHCP:

- ADSMs
- National Guard and Reserve members on active duty
- National Guard and Reserve members authorized for LOD care
- National Oceanic and Atmospheric Administration personnel, U.S. Public Health Service personnel and Reserve Officer Training Corps (ROTC) students, cadets or midshipmen
- Eligible foreign military personnel (for outpatient care only)
- Any non-TRICARE–eligible person who receives approval from a military hospital or clinic to receive civilian services under SHCP (those with Medicare are not eligible for SHCP except if they are inpatient at a military hospital or clinic and, while remaining inpatient, require civilian diagnostic services that cannot be performed at the military hospital or clinic)
- Beneficiaries on the Temporary Disability Retired List are eligible to obtain required periodic physical examinations
- Medically retired former members of the armed services enrolled in the Federal Recovery Coordination Program

## Authorization Process

- A civilian or military provider submits a request to HNFS for review.
- HNFS reviews the request for TRICARE coverage. HNFS will deny requests for services not covered by TRICARE (including those listed on the government no-pay list) unless a DHA approval is present or the medical condition is exempt from the DHA waiver process. Refer to the ***Authorization Denials*** section of this handbook.
- HNFS will review requests for services NOT specifically excluded by TRICARE against TRICARE coverage guidelines and approve or deny the request based on this review.

**Note:** In some cases, HNFS must request additional information to determine if the requested services meet TRICARE benefit coverage criteria. Providers must submit this additional information to HNFS by the date indicated in the Additional Information Request Letter or the authorization request will be canceled. It is extremely important providers respond to these information requests in a timely manner, especially for services requested on an urgent basis.

If a request is canceled due to non-receipt of requested information, the DHA waiver process does not apply, as TRICARE benefit coverage could not be determined. Instead, the provider must submit a new authorization request to HNFS, along with the requested information, to undergo the benefit determination review.

### Authorization Denials

- ADSMs receiving a denial letter for non-covered services will be given instructions that a waiver from DHA is required. ADSMs, who do not have TPR, should coordinate the waiver with their military hospital or clinic of enrollment.
- ADSMs who have TPR will contact their Uniformed Services Headquarters point of contact (POC)/Service Project Officer for waiver consideration. (**Note:** This is not the same as the SAS at DHA-GL.) The denial letter will contain contact information. If the episode of care related to the denied service is being managed by a military hospital or clinic, then the TPR ADSM should coordinate the waiver with the military hospital or clinic managing the episode of care.
- Once the waiver is requested, the Director of DHA will review.
- Beneficiaries should follow up with their military hospital or clinic (non-TPR) or Uniformed Services Headquarters POC/ Service Project Officer (TPR ADSM) for status checks of any waiver requests that have been submitted. The contact information will be included in the denial letter.
- If DHA approves the waiver, HNFS will approve the requested services.
- ADSMs may receive a denial letter for covered services requested in the civilian network environment if HNFS is directed by the military hospital or clinic or DHA to deny the request (for example, the military hospital or clinic or DHA is requiring care be performed within the direct care system or there are fitness for duty concerns). In these instances, the denial letter from HNFS will include instructions for the ADSM to contact the military hospital or clinic or DHA-GL for any appeal considerations.

SHCP beneficiaries are not responsible for copayments, cost-shares or deductibles. Refer to the *"**Claims Processing and Billing Information**"* section of this handbook for SHCP claims submission information.

# Transitional Health Care Benefits

TRICARE offers the following program options for beneficiaries separating from active duty.

### Continued Health Care Benefit Program

The **CHCBP** is a premium-based health care program administered by Humana Military. The CHCBP offers temporary transitional health care coverage (18-36 months) after TRICARE eligibility ends and acts as a bridge between military health care benefits and the beneficiary's new civilian health care plan. CHCBP benefits are comparable to TRICARE Select, but there are differences. The main difference is that beneficiaries must pay quarterly premiums. Additionally, under CHCBP, providers are not required to use or coordinate with military hospitals and clinics, and military hospital and clinic non-availability statements are no longer required.

Providers must coordinate with Humana Military to obtain pre-authorizations and referrals for CHCBP beneficiaries. Medical necessity rules for CHCBP beneficiaries follow TRICARE Select guidelines. For more information about CHCBP, visit Humana Military's **Continued Health Care Benefit Program** web page or call **1-800-444-5445**. HNFS cannot provide assistance or information concerning CHCBP.

### Transitional Assistance Management Program

**TAMP** provides 180 days of transitional health care benefits to help certain uniformed services members and their families transition to civilian life after separating from active duty service.

Qualifying beneficiaries may enroll in TRICARE Prime (if located in a PSA) or TRICARE Select. Rules and processes for these programs apply, and beneficiaries are responsible for ADFM costs.

TAMP beneficiaries must present valid USIDs or CACs at the time of service. Refer to the *"**TRICARE Eligibility**"* section of this handbook for information about verifying eligibility.

For more information about TAMP, visit TRICARE's **Transitional Assistance Management Program** web page.

**Note:** TAMP does not cover LOD care. Refer to *"**Line of Duty Care for National Guard and Reserve Members**"* and *"**Supplemental Health Care Program**"* earlier in this section for possible coverage details.

### Transitional Care for Service-Related Conditions Program

Former ADSMs and National Guard and Reserve members who have **TAMP** coverage may qualify for Transitional Care for Service-Related Conditions (TCSRC), which extends their TRICARE coverage beyond the usual 180-day TAMP coverage time frame.

Eligible beneficiaries receiving TAMP coverage, who have a newly diagnosed medical condition related to their active duty service, may qualify for an additional 180-day period of coverage for their specific service-related condition.

TCSRC applies only to the specific service-related condition and must be:

- Diagnosed during TAMP coverage.
- Able to be resolved within 180 days.
- Approved by the DOD.

**Note:** Once the DOD validates a medical condition eligible for TCSRC, coverage will show in the DEERS.

Providers and beneficiaries should fill out the **TCSRC Application Worksheet**. Providers need to be as detailed as possible in the worksheet. They also should provide care notes regarding the connection between the medical condition and active duty service and a treatment plan that ensures the condition can be resolved in the 180-day TCSRC extension time frame.

Beneficiaries should mail the worksheet and all other supporting documentation, as well as a TCSRC request letter, to DHA-GL at:

Defense Health Agency-Great Lakes
PO Box 886999
Great Lakes, IL 60088-6999

For more information on TCSRC, visit TRICARE's **Transitional Care for Service-Related Conditions** web page.

# Medical Coverage

## Medical Coverage

TRICARE only covers health care services and devices that are medically necessary and considered proven. Some types of care have limitations. Beneficiary liability for covered services varies according to TRICARE program options. Refer to ***TRICARE Program Options*** in the ***TRICARE Eligibility*** section of this handbook for specific beneficiary liability information.

This section provides an overview of TRICARE-covered services and includes specific details about certain benefits. This section is not all-inclusive, and services listed as TRICARE-covered services are subject to change. For additional benefit details and the most up-to-date information about TRICARE-covered services, visit **Benefits A–Z** at **www.tricare-west.com**.

Some military hospitals and clinics may offer services or procedures TRICARE does not cover. Beneficiaries should contact their local military hospital or clinic for information about these services. The Defense Health Agency (DHA) Deputy Director may authorize services that are not TRICARE benefits for active duty service members (ADSM). Providers may be reimbursed for these services only if they obtain pre-authorization from Health Net Federal Services (HNFS).

## Network Utilization

When care cannot be provided at a military hospital or clinic, TRICARE network providers become the first option to render beneficiary care. In most cases, beneficiary care can be arranged swiftly through the TRICARE provider network while simultaneously meeting access-to-care standards. Requests for specialty care referrals or outpatient treatment authorizations to non-network providers will be redirected to TRICARE network providers of the same specialty when applicable and whenever possible.

**Note:** Providers requesting coverage for certain limited benefit services can refer to our **Letters of Attestation** (LOA) web page for additional authorization information. The LOAs guide providers to the information required for HNFS to review the service for possible approval. Providers should attach completed LOAs to their pre-authorization requests.

# Covered Services

**Covered Services, Figure 4.1**

| TRICARE Covered Services and Authorization Guidelines | | |
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| **Service** | **Coverage Details** | **Pre-Authorization Requirements** |
| **Adjunctive dental care** | Dental benefits are available under the separate TRICARE dental programs. Limited adjunctive dental services may be covered when related to other covered medical care.<br>The following are special circumstances covered under the adjunctive dental care benefit:<br>• Facility services required to safeguard the life of the beneficiary – some patients have medical conditions that could become life-threatening during routine dental procedures (for example, tooth extraction for a hemophiliac).<br>• Children aged five years and younger, and beneficiaries with severe developmental, mental or physical disabilities undergoing routine dental procedures:<br>– TRICARE covers the facility services, supplies and anesthesiology services. Under this category, TRICARE does not cover the professional dental services and anesthesiology services rendered by the attending dentist.<br>– TRICARE will cover anesthesiology services rendered by a separate anesthesiology provider.<br>**Note:** Acute anxiety, mental issues and extensive dental treatment do not qualify beneficiaries for adjunctive dental care. The beneficiary must have a diagnosis from their provider of mental illness or disability that prohibits safe dental treatment. | Except for emergency care, adjunctive dental care requires pre-authorization from HNFS for all beneficiaries. |
| **Applied behavior Analysis (ABA)** | ABA uses behavioral modification techniques to modify behavior as part of a learning or treatment process. TRICARE covers ABA services under its Autism Care Demonstration (ACD).<br>Refer to our **Autism Care Demonstration** page for eligibility requirements, benefits and costs, initial and ongoing authorization guidelines, treatment plan requirements, billing and claims, provider types and requirements, answers to frequently asked questions, and other ACD-related topics. | ABA services require pre-authorization from HNFS for all beneficiaries, including those with other health insurance (OHI). |
| **Durable equipment (DE)/durable medical equipment (DME), prosthetics, orthotics and supplies (DMEPOS)** | • DE is a medically necessary item that can withstand repeated use and primarily and customarily serves a medical purpose. Covered items that may be provided to a beneficiary as DE include DME, hospital beds and wheelchairs.<br>• Some DMEPOS are a limited benefit (for example, wigs, prosthetics, orthotics, and hearing aids).<br>• Diabetic equipment is covered under the TRICARE medical program as DME.<br>• Physicians, dentists or any TRICARE-authorized allied health care professional may order or prescribe DE/DMEPOS when acting within the scope of their license or certification.<br>• Companies that provide DMEPOS within military hospitals and clinics may not bill TRICARE for the items provided. This includes, but is not limited to, crutches, wheelchairs, continuous positive airway pressure (CPAP) equipment, knee braces, splints, and foot orthotics. Payment should come directly from the military hospital or clinic. | • ADSMs require an approval from HNFS for all DMEPOS items.<br>• TRICARE Prime beneficiaries require an approval from HNFS for all DMEPOS items, rentals and repairs.* If an approval is not on file, point-of-service charges may apply. If the purchase price of an item is $2,000 or more and an approval is not on file, a 10 % penalty will also apply.<br>• Any DMEPOS with a purchase price of $150 or greater and all rental items regardless of the price require a certificate of medical necessity (CMN) to be submitted with a claim (unless pre-authorized).<br>**DMEPOS items considered inexpensive according to the Centers for Medicare & Medicaid Services' (CMS) guidelines, such as gauze, tape and crutches, do not require a referral from HNFS. (Check the* **CMS DMEPOS Fee Schedule** *for details.)* |

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| **Emergency care** | • Emergency conditions are those that threaten life, limb or eyesight, or safety.<br>• Emergency conditions include medical, maternity or psychiatric problems that would lead someone to believe a situation exists that without medical help could lead to loss of life, limb or eyesight.<br>• An emergency may also include the need for immediate help to treat severe pain or relieve suffering. | • Emergency care (that meets TRICARE criteria) does not require pre-authorization from HNFS.<br>• TRICARE Prime beneficiaries must coordinate all follow-up care with their primary care managers (PCMs) to avoid point-of-service costs. If the TRICARE Prime beneficiary does not have an assigned PCM, the beneficiary must coordinate all follow-up care with HNFS.<br>• If a beneficiary is admitted, authorization may be required. TRICARE providers must notify HNFS of an emergency room inpatient facility admission and discharge date within 24 hours or by the next business day following both admission and discharge.<br>• TRICARE Select, TRICARE For Life (TFL) and beneficiaries with OHI do not need to coordinate any follow-up care with HNFS, but they should notify their family physician of an emergency room visit. |
| **Home health care** | • Home health care is covered for skilled nursing care and physical, speech and occupational therapies, for a maximum of 28 hours per week part time or 35 hours per week intermittently.<br>• Home infusion therapy is a limited benefit. The type of medication and length of administration will determine whether the home infusion/injection medication will be paid under the medical benefit or through the TRICARE pharmacy benefit. | • Home health care requires pre-authorization from HNFS for all beneficiaries.<br>• Except for individuals with OHI, home infusion therapy requires pre-authorization from HNFS. |
| **Hospice care** | • Hospice care is a limited benefit covering palliative care for those with six months or less to live.<br>• Beneficiaries who receive care under hospice cannot receive curative treatment related to the terminal illness unless hospice has been revoked (exception for beneficiaries under age 21, who are exempt from this requirement and can receive curative treatment concurrently while receiving hospice services).<br>• There may be separate charges for DME, prosthetics and specific drugs with applicable copayments and cost-shares.<br>• Room and board are not covered under hospice care unless the patient is receiving authorized inpatient or respite-level care. | Hospice care requires pre-authorization from HNFS for all beneficiaries. |
| **Hospitalization** | Inpatient hospitalization is a covered benefit and includes:<br>• semiprivate room (and, when medically necessary, special care units)<br>• general nursing<br>• hospital service<br>• inpatient physician and surgical services<br>• meals (including special diets)<br>• drugs and medications while an inpatient<br>• operating and recovery room<br>• anesthesia, laboratory tests<br>• X-rays and other radiology services<br>• necessary medical supplies and appliances, and blood and blood products. | • Non-emergency inpatient admissions may require pre-authorization from HNFS.<br>• HNFS requires notification of inpatient facility admissions and discharge dates by the next business day following both the admission and discharge. |
| **Maternity care**<br>(also refer to *Maternity Care* section in this handbook) | Global maternity care includes prenatal care from the first obstetric visit, labor and delivery, postpartum care for up to six weeks after the birth of the child, and treatment of complications.<br>**Note:** An office visit to determine or confirm pregnancy is not considered part of global maternity care and is covered separately as an office visit. | • TRICARE Prime beneficiaries require a referral from HNFS for civilian professional maternity care services (for example, obstetrics and gynecology (OB/GYN) or nurse midwife).<br>• HNFS requires notification of the inpatient admission and birthing center notification of delivery within 24 hours of admission or the next business day. |

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| **Physical therapy (PT)/ Occupational therapy (OT)/Speech therapy (ST)** | Coverage is based on the beneficiary's medical needs. The number of visits authorized indicates the actual number of visits, not the individual units per Current Procedural Terminology (CPT®) code. The following baselines will be used as a guide for the number of visits and duration of approval:<br>• Acute injuries: 12 visits within a 120-day period<br>• Post-operative care: 24 visits within a 150-day period<br>• Long-term conditions: 72 visits within a 180-day period<br>**Note:** PT is covered when rendered and billed by a licensed, registered physical therapist or other authorized professional provider acting within the scope of his or her license. Services performed by a supervised licensed physical therapy assistant must be billed under the licensed physical therapist's National Provider Identifier (NPI) number. | • PT/OT/ST require pre-authorization from HNFS for TRICARE Prime and TRICARE Prime Remote (TPR) beneficiaries with an assigned PCM.<br>• Pre-authorization from HNFS is not required for TPR beneficiaries without an assigned PCM and TRICARE Select beneficiaries; however, a physician's order is required for claims processing. |
| **Skilled nursing facility (SNF) care** | An SNF admission is covered when both of the following conditions have been met:<br>• The beneficiary has a qualifying hospital stay of three consecutive days or more, not including the hospital discharge day; and<br>• The beneficiary enters the SNF within 30 days of discharge from the hospital.<br>There is no day limit while medical necessity continues.<br>TRICARE has adopted Medicare's interrupted stay policy for SNF admissions. An interrupted SNF stay is one where a patient is discharged from an SNF and subsequently readmitted to the same SNF within three days. The three-day interruption or leave of absence window begins on the first non-covered day following the SNF stay and ends at 11:59 p.m. on the third consecutive non-covered day. | • ADSMs: SNF admissions require pre-authorization from HNFS.<br>• All other TRICARE Prime beneficiaries:<br>– Pre-authorization from HNFS required for continued stays expected to go beyond 100 days.*<br>– Providers must submit the request to HNFS and include all applicable clinical information for review.<br>**Pre-authorization is required for Medicare-eligible TRICARE beneficiaries on day 101 of the inpatient stay when TRICARE becomes the primary payer. Authorization requests must be submitted to Wisconsin Physicians Service (WPS) for approval.* |
| **Urgent care** | Urgent care services are medically necessary services required for illness or injury that would not result in further disability or death if not treated immediately but do require professional attention within 24 hours. Conditions such as sprains, sore throats and rising temperatures may require urgent care because they have the potential to develop into emergencies if treatment is delayed longer than 24 hours. | **TRICARE Prime plans**<br>ADSMs enrolled in TRICARE Prime require a referral for urgent care; however, ADSMs enrolled in TPR do not require a referral due to their remote location.<br>TRICARE Prime beneficiaries, not including ADSMs, do not need a referral for urgent care and point-of-service will not apply when seeking urgent care from the following:<br>• Any network or non-network urgent care center (must be TRICARE authorized)<br>• Any network primary care type provider (family practice, general practice, internal medicine, pediatrics, OB/GYN, physician assistant, nurse practitioner, or certified nurse midwife)<br>**All other plans**<br>There is no referral requirement for urgent care, and care may be rendered by any network or non-network provider (must be TRICARE authorized).<br>**Note:** TRICARE Overseas Program enrollees who are traveling and seeking stateside urgent care do not require a referral. |

## Clinical Preventive Services, Figure 4.2

| Covered Clinical Preventive Services | |
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| **Service** | **Benefit Details** |
| **Blood lead testing** | Blood lead testing, an assessment of risk for lead exposure, is a covered benefit when performed during well-child care visits from six months through age five years for all children determined to be high risk. |
| **Cancer screenings** | **Colonoscopy (optical/conventional)**<br>One every 10 years, ages 45 years and older<br>**Computed tomographic (CT) colonography**<br>Every 5 years, ages 45 years and older<br>**Fecal Immunochemical testing (FIT)**<br>One stool sample every 12 months<br>**FIT-DNA:**<br>Every 1 to 3 years, ages 45 years and older<br>**Fecal occult blood test (FOBT)**<br>Every 12 months for all beneficiaries ages 45 years and older<br>**Magnetic resonance imaging (MRI) breast screenings**<br>Beginning at age 30 years for beneficiaries considered to be at high risk of developing breast cancer, screening breast MRIs are covered annually in addition to the annual screening mammogram. High-risk indicators are:<br>• A lifetime risk of breast cancer of 20 percent or more using standard risk assessment models such as: Gail model, Claus model or Tyrer-Cuzick.<br>• Known BRCA1 or BRCA2 gene mutation.<br>• A parent, child or sibling with a BRCA1 or BRCA2 gene mutation, and the beneficiary has not had genetic testing for this mutation.<br>• Radiation therapy to the chest between 10-30 years of age.<br>• History of LiFraumeni, Cowden or Bannayan-Riley-Ruvalcaba syndrome, or a parent, child or sibling with a history of one of these syndromes.<br>**Mammogram**<br>One screening mammogram every 12 months for women with average risk beginning at age 40 years. Women with a high risk of breast cancer may receive a screening mammogram beginning at age 30 years. ADSMs require pre-authorization from HNFS. TRICARE Prime (when seeing a network provider) and TRICARE Select beneficiaries do not require pre-authorization from HNFS.<br>**Note:** Digital breast tomosynthesis (DBT), also known as a three-dimensional (3D) rendering mammogram, is covered for routine screening through TRICARE's provisional coverage program.<br>**Pap Test**<br>Cancer screening Pap tests are covered for female beneficiaries beginning at age 21 years. The frequency of screening Pap tests is at the discretion of the beneficiary and provider; however, they should be performed at least once every three years. Women under age 21 years should not be screened regardless of the age of sexual initiation or other risk factors.<br>*A grace period allows a Pap test 30 days prior to the anniversary date of the last exam.<br>**Sigmoidoscopy**<br>Every five years beginning at age 45 years<br>**Sigmoidoscopy with annual FIT**<br>Every 10 years beginning at age 45 years<br>**Prostate cancer screening**<br>Every 12 months when provided as part of a health promotion and disease prevention (HP&DP) exam.<br>The screening includes a digital rectal exam and prostate-specific antigen screening for:<br>• Men aged 40 years and older with a family history of prostate cancer in two or more other family members.<br>• Men aged 45 years and older with a family history of prostate cancer in at least one other family member.<br>• All African-American men aged 45 years and older regardless of family history.<br>• All men aged 50 years and older.<br>**Skin cancer screening**<br>Skin cancer screening exams are covered at any age for beneficiaries with family or personal history of skin cancer, increased exposure to sunlight or clinical evidence of precursor lesions. |

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| **Cardiovascular** | Cardiovascular disease screenings are a covered benefit and include cholesterol and blood pressure checks.<br>**Cholesterol Testing**<br>Cholesterol testing is a covered benefit:<br>• Once between the ages of nine 9 years and 11 years and again<br>• Once between the ages of 17 years and 21 years.<br>• For men and women at increased risk of coronary disease:<br>o Screen men ages 35 years and older<br>o Screen men and women ages 20 years and older<br>**Blood Pressure Checks**<br>• TRICARE recommends blood pressure checks for children at least every 2 years after age 6. |
| **Contraceptive Care** | Contraceptive care is a covered benefit. |
| **Health Promotion and Disease Prevention Examinations (HP&DP)** | HP&DP examinations are covered if one of the following clinical preventive services is ordered or rendered during the visit:<br>• A covered immunization<br>• Cervical cancer screening, for example, Pap test<br>• Breast cancer screening, for example, mammogram<br>• Colorectal cancer screening<br>• Prostate cancer screening<br>HP&DP exam claims usually include a general medical examination diagnosis (V70 or V70.0). A separate diagnosis code for an immunization, screening Pap test, breast cancer screening, colorectal cancer screening, or prostate cancer screening is required for claims payment. Refer to the individual services in this section for frequency of coverage.<br>In addition to the above, TRICARE Prime and TRICARE Select beneficiaries aged 6 years and older may receive one HP&DP exam annually without one of the clinical preventive services above, when rendered by a network provider. While often rendered by a PCM, HP&DP exams and accompanying immunizations and screenings may be performed by any other network provider within the beneficiary's region of enrollment without a referral.<br>**Note:** If a cancer screening or immunization is not performed or ordered during an HP&DP exam outside of the one allowance per year (for TRICARE Prime and TRICARE Select beneficiaries who see a network provider) as noted above, the preventive exam may not be covered. |
| **Hearing** | Hearing screenings are only covered for high-risk newborns as defined by The Joint Committee on Infant Hearing and should be performed before the newborn is discharged from the hospital or within the first 3 months. Evaluative hearing tests may be performed at other ages during preventive exams.<br>**Note:** Hearing aids, including bone-anchored, and hearing aid services are only covered benefits for beneficiaries and service members with profound hearing loss. Hearing aids and hearing aid services are not covered for retirees and their family members, TRICARE Reserve Select (TRS) members and TRICARE Retired Reserve (TRR) members. |
| **Immunizations** | The TRICARE preventive services benefit includes age-appropriate vaccines (including influenza vaccines) only as recommended and adopted by the Advisory Committee on Immunization Practices (ACIP), accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services, and published in the CDC's **Morbidity and Mortality Weekly Report** (MMWR). Refer to the **CDC's** website for a current schedule of recommended vaccines.<br>**Note:** Immunizations required for ADFMs whose sponsors have permanent change of station orders to overseas locations are also covered. You must include a copy of the sponsor's change of station orders when filing the claim. TRICARE does not cover immunizations for personal overseas travel. |
| **Infectious disease screening** | TRICARE covers screening for individuals who have been exposed or are at high risk for several infectious diseases, including hepatitis B and human immunodeficiency virus (HIV). Pregnant women may be screened for hepatitis B, HIV and rubella antibodies.<br>Beneficiaries at risk for active disease are eligible for screening and/or prophylaxis for tetanus, rabies, hepatitis A and B, meningococcal meningitis, and tuberculosis. |
| **Vision coverage** (also see Eye Examination section below) | Routine and comprehensive eye exams not related to another medical or surgical condition are a limited benefit under TRICARE. Coverage differs by beneficiary category, age and TRICARE program. |
| **Well-child care** (birth through age five) | Well-child care is a covered benefit and includes routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight and head circumference; routine immunizations; and developmental and behavioral appraisal. TRICARE covers well-child care in accordance with the American Academy of Pediatrics guidelines, which recommend exams (with specific screenings) at: newborn; 3 to 5 days; by 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 3 years, and 4 years; and through age 5. |
| **Well-woman exam** | Health promotion and disease prevention exams for the purpose of a well-woman exam are covered annually for female beneficiaries under age 65 years. If the provider determines a beneficiary requires additional well-woman visits to obtain all necessary recommended preventive services that are age and developmentally appropriate, these may be provided without cost-sharing and subject to reasonable medical management. There is no requirement a well-woman exam be rendered in connection with a covered cancer screening or immunization. |

# Cancer Clinical Trials

Cancer clinical trials may be cost-shared for beneficiaries participating in the National Cancer Institute (NCI) sponsored Phase I, Phase II and Phase III studies for the prevention, screening, early detection, and treatment of cancer.

Pre-authorization is required before the initial evaluation and should be requested from the TRICARE West Clinical Trial Coordinator at 1-**855-722-5837**. The institutional and individual providers must be TRICARE authorized and treatments must be NCI-sponsored Phase I, Phase II and Phase III protocols.

# COVID-2019

***Clinical Trials***

As of April 11, 2023, TRICARE will no longer cover National Institute of Allergy and Infectious Disease (NIAID)-sponsored COVID-19 clinical trials. Eligible beneficiaries who enrolled in a covered trial on or before April 10, 2023, will continue to have their care covered through the end of the trial so long as TRICARE requirements are met.

***Testing***

COVID-19 diagnostic and antibody (serology) testing is a covered benefit when medically necessary. Beneficiaries suspected to have COVID-19 should be tested following CDC guidelines. COVID-19 diagnostic and antibody tests must meet Families First Coronavirus Response Act (FFCRA) criteria.

Diagnostic testing required prior to a procedure or admission may be considered medically necessary and appropriate.

To be considered for coverage, antibody tests must be rendered to diagnose and/or treat beneficiaries. Antibody tests are not a covered benefit when performed:

- On asymptomatic patients;
- To satisfy patient curiosity;
- To determine a patient's ability to return to work or school;
- To determine a donor's ability to donate blood or plasma; and/or
- As part of epidemiological research, surveillance studies or for other public health reason.

In vitro diagnostic tests using Reverse Transcription Polymerase Chain Reaction (RTPCR) for asymptomatic ADSMs may also be considered for coverage when ordered by a TRICARE-authorized provider. CPT code 87635 with special processing code 'CV' should be used when billing this test. Additionally, code Z11.59 can be used to properly diagnosis an asymptomatic patient.

There are no approval requirements specific to COVID-19 diagnostic and antibody testing from HNFS. There are no utilization limits for how often a COVID-19 test can be provided; however, it must be medically necessary and appropriate as indicated above. If requesting a benefit review for an antibody (serology) test, providers may attach a Letter of Attestation (LOA) in lieu of clinical documentation to the request.

***Vaccines***

COVID-19 vaccines are covered in accordance with CDC guidelines. An approval from HNFS is not required.

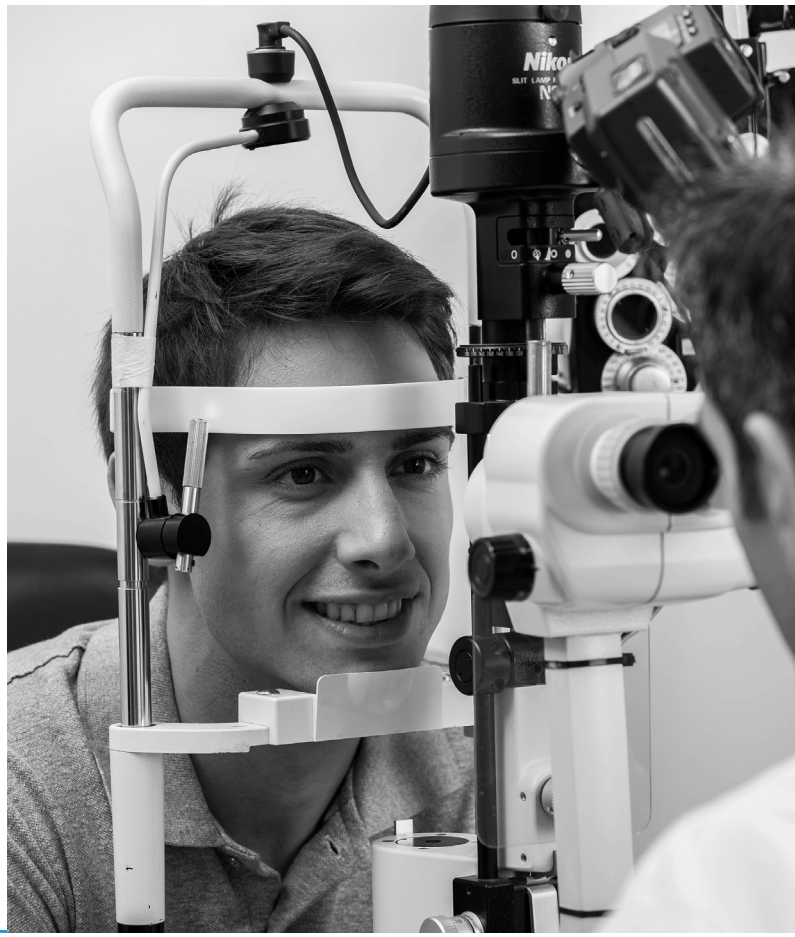
# Eye Examinations

***Routine Eye Exams***

Routine eye exams are a limited benefit under TRICARE and coverage differs by beneficiary category and plan type. A routine eye exam may include, but is not limited to: refractive services, ocular alignment and red reflux, dilation and external examination for ocular abnormalities. The covered CPT codes are 92002, 92004, 92012, 92014, and 92015.

For all beneficiaries, the primary diagnosis on the claim should be routine vision screening. Routine vision screening exams for diabetic patients are covered more frequently. The primary diagnosis on the claim should be routine vision screening, with diabetes listed as a secondary diagnosis. Failure to include the routine diagnosis or using an evaluation and management (E&M) procedure code may cause the claim to process as a diagnostic exam. Refer to the ***Claims Processing and Billing Information*** section of this handbook for specific eye examination billing information.

**Note:** Beneficiaries who recently transitioned from active duty to retired status may receive one routine eye exam every 24 months under the TRICARE Prime benefit regardless of date of the last eye exam received under active duty benefits.



**Routine Eye Exams by Beneficiary Category, Figure 4.3**

| Beneficiary | | Coverage | Provider |
|---|---|---|---|
| **Active duty service member** | TRICARE Prime | As needed to maintain fitness for duty | Military hospital or clinic, unless specifically referred |
| | TRICARE Prime Remote (TPR) | One routine eye exam annually (once every 12 months) | Network or non-network optometrist or ophthalmologist |
| **Active duty family member** | TRICARE Prime, TPR with an assigned primary care manager (PCM), TRICARE Select (network provider) | One routine eye exam annually (once every 12 months) | Network optometrist or ophthalmologist |
| | TPR without an assigned PCM | One routine eye exam annually (once every 12 months) | Network or non-network optometrist or ophthalmologist |
| | TRICARE Select | One routine eye exam annually (once every 12 months) | Network or non-network optometrist or ophthalmologist |
| | TRICARE Reserve Select (TRS) | One routine eye exam annually (once every 12 months) | Network or non-network optometrist or ophthalmologist |
| **Retirees and their Families** | TRICARE Prime | One routine eye exam every 24 months for ages three and older | Network optometrist or ophthalmologist |
| | TRICARE Select | One routine eye exam every 24-month period for beneficiaries ages three through five. Routine eye exams are not covered for beneficiaries ages six and older. | Network or non-network optometrist or ophthalmologist |
| | TRICARE Retired Reserve (TRR) | One routine eye exam every 24-month period for beneficiaries ages three through five. Routine eye exams are not covered for beneficiaries ages six and older. | Network or non-network optometrist or ophthalmologist |

### Non-Routine (Diagnostic) Eye Exams

TRICARE Prime (TRICARE Prime, TPR, TRICARE Young Adult [TYA] Prime) beneficiaries require an approval from HNFS for all diagnostic eye exams by network or non-network optometrists or ophthalmologists. TRICARE Select beneficiaries do not require an approval from HNFS. TRICARE covers diagnostic exams for the treatment of a confirmed or suspected eye condition. A diagnostic exam may be billed with E&M procedure codes like 992xx along with the appropriate diagnosis code identifying the patient's eye condition. A diabetes diagnosis could be the primary diagnosis or a secondary diagnosis. Diagnostic exams can be billed with eye exam CPT codes 92002, 92004, 92012, 92014, 92015, or the E&M codes.

CPT codes 99172 (visual function screening) and 99173 (visual acuity screening) are examinations considered to be an integral part of an office visit or well-child visit. CPT codes 99172 and 99173 cannot be separately reimbursed when billed with a well-child or E&M office visit (CPT codes 99381– 99397), whether or not a -59 modifier is used. Providers may view the **TRICARE Policy Manual (TPM)**, Chapter 7 for complete details.

### Vision Screening for Newborns

Vision screenings for newborns aged zero to 24 months, regardless of beneficiary category, are covered when rendered by the primary care provider during routine well-child examinations.

## Laboratory Developed Tests

A laboratory developed test (LDT) is a diagnostic test that is designed, manufactured, and used within a single laboratory. For an LDT to be considered for coverage, the following criteria must be met:

- The LDT must be listed in the **TRICARE Operations Manual (TOM)**, Chapter 18, Section 3,
- The laboratory must be a TRICARE-authorized and Clinical Laboratory Improvement Amendments (CLIA)-certified provider,
- The beneficiary must have received counseling regarding the requested genetic test, and
- The beneficiary must meet the coverage criteria for the requested test.

Some LDTs are not yet approved by the U.S. Food and Drug Administration (FDA) but are covered under the LDT Demonstration Project. The purpose of the TRICARE LDT Demonstration Project is to improve the quality of health services for TRICARE beneficiaries. The demonstration allows TRICARE the opportunity to review a limited list of CMS-approved LDT tests not yet approved by the FDA to determine if they are safe and effective for use.

LDTs that are not part of the TRICARE LDT Demonstration Project but are FDA approved and for which the results of the test will influence the medical management of the individual or pregnancy, are TRICARE basic benefits.

### Authorization

Pre-authorization is required for all LDTs, except cystic fibrosis testing.* Please refer to our **LDT Coverage Criteria Guide**, as it specifies coverage requirements for each LDT. Providers must also complete an LDT LOA, which should be attached to the pre-authorization request submitted via CareAffiliate® (recommended) or submitted with the claim. Providers requesting more than one LDT need only submit one LOA with multiple tests indicated on that form.

Laboratories performing LDTs should ensure the ordering provider has obtained pre-authorization or completed an LDT LOA prior to performing the test.

HNFS authorizes LDTs in accordance with the **TOM**, Chapter 18, Section 3. Providers who perform LDT procedures more than once should use the appropriate modifiers and the claim will be processed accordingly. Claims submitted without pre-authorization and/or a completed LOA will be denied.

- If the LDT is listed in the **TOM**, Chapter 18, section 3 and it meets the requirements listed in the LDT Coverage Criteria Guide, the test will be covered under the LDT Demonstration.
- If the LDT test is not included in the LDT Demonstration Project, but is FDA approved as noted per the **FDA DeNovo 510K** or **Premarket Approvals** (PMA) databases, and the results will influence the medical management of the beneficiary, the test will be covered under the basic benefit.

*TRICARE covers preconception and prenatal carrier screening under the TRICARE basic benefit for the following conditions: cystic fibrosis, spinal muscular atrophy, fragile X syndrome, Tay-Sachs disease, hemoglobinopathies, and conditions linked with Ashkenazi Jewish descent.

## Maternity Care

TRICARE Prime (TRICARE Prime, TPR, TYA Prime) beneficiaries require a referral from HNFS for civilian professional maternity care services (for example, obstetrics and gynecology [OB/GYN] or certified nurse midwife). Hospitals must let HNFS know about inpatient admissions and birthing centers must notify HNFS about deliveries within 24 hours of admission or the next business day.

TRICARE Select beneficiaries can obtain all maternity care without a pre-authorization or referral from HNFS.

**Note:** When using a birthing care center, be sure it is TRICARE certified.

Covered services include:

- Epidural anesthesia for pain management during delivery
- Medically necessary maternity ultrasounds
- Deliveries at TRICARE-authorized birthing centers
- Emergency and medically necessary Cesarean sections (C-sections) (Cost-sharing for services and supplies related to elective C-sections [those done at the request or convenience of the beneficiary] is limited to what would have been provided for vaginal delivery.)
- Prenatal vitamins that require a prescription
- Home delivery when performed by a TRICARE network or non-network provider, including a certified nurse midwife
- Preconception and prenatal carrier screening for the following conditions:
  - Cystic fibrosis
  - Spinal muscular atrophy
  - Fragile X syndrome
  - Tay-Sachs disease
  - Hemoglobinopathies
  - Conditions linked with Ashkenazi Jewish descent
- Prenatal screenings such as:
  - Anemia,
  - Asymptomatic bacteriuria, urinary tract or other infections,
  - Gestational diabetes mellitus,
  - Hepatitis B,
  - HIV infection,
  - Rh incompatibility,
  - Syphilis infection, and
  - Other screening tests as recommended by the United States Preventive Services Task Force.

Be aware of conditions that can lead to **postpartum depression**. Information on surrogacy can be found on our **Benefits A–Z** web page.

### Fetal Surgery Referral Line

Pregnant TRICARE beneficiaries who have a fetal condition or suspected fetal condition and their providers have access to a dedicated call center option to request an expedited referral for fetal surgery. Call the HNFS Case/Care Support line at **1-844-524-3578** between 9 a.m.–6 p.m. (local time) and choose option 4 for maternity fetal support.

### Banked Donor Milk

TRICARE may cover banked donor milk for critically ill infants who meet one or more of the following conditions:

- Born at a very low birthweight (<1,500g);
- Gastrointestinal anomaly, metabolic/digestive disorder or recovery from intestinal surgery when digestive needs require additional support;
- Diagnosed with failure-to-thrive (not appropriately gaining weight/growing);
- Formula intolerance, with documented feeding difficulty or weight loss;
- Infant hypoglycemia (low blood sugar);
- Congenital heart disease;
- Pre- or post-organ transplant; or
- Other serious health conditions when the use of banked donor milk is medically necessary and supports the treatment and recovery of the infant,

and

- The mother's milk is insufficient to meet the baby's needs.

**Note:** If the birth mother is unavailable due to physical absence in uncommon circumstances (for example, adoption, the mother's death, deployment of ADSM mother), the own mother's milk is considered to be unavailable. Beneficiaries must have a prescription from a TRICARE-authorized provider that specifies the banked donor milk quantity and frequency needed. The initial prescription is valid for 30 days, and coverage is limited to no more than 35 ounces per day, per infant. Coverage may be extended in 30-day intervals through 12 months of age, when medically necessary and with a new prescription. Covered donor milk must come from human milk banks accredited by the Human Milk Banking Association of North America.

Visit **www.hmbana.org/find-a-milk-bank** to find the nearest accredited milk bank.

An approval from HNFS is not required for banked donor milk; however, the prescription and supporting medical documentation is required to complete claims processing. In lieu of separate clinical documentation, the treating provider can complete a Banked Donor Milk Coverage Criteria Attestation to be submitted with the claim. To access this letter of attestation, please visit our **Letters of Attestation** page online.

## Breast Pumps and Supplies

TRICARE covers breast pumps and breast pump supplies beginning at week 27 of pregnancy or the birth of a child, if prior to 27 weeks, and for female beneficiaries who legally adopt an infant and intend to personally breastfeed the adopted infant.

***Breast pumps***

TRICARE covers one manual or electric breast pump per birth or adoption. An approval from HNFS is only required for ADSMs who are prescribed a hospital-grade breast pump. All beneficiaries must have a prescription from a TRICARE network or TRICARE-authorized non-network physician, physician assistant, nurse practitioner, or certified nurse midwife. The prescription must specify the type of breast pump prescribed (manual, standard electric or hospital-grade electric) and include the number of weeks the beneficiary is pregnant or age of the infant at the time of the prescription. Currently, there are no restrictions on the brand or model of pump. However, the breast pump purchased must match the type of pump prescribed. Heavy duty hospital-grade electric breast pumps may be covered as long as use is determined to be medically necessary and appropriate. When prescribing a hospital-grade breast pump, supporting medical documentation is required.

**Note:** When the hospital-grade breast pump is no longer needed, a manual or standard electric breast pump may be covered with a new prescription.

***Breast pump supplies***

One breast pump kit is covered per birth event but may not be reimbursed separately.

Replacement supplies are covered as follow (no separate prescription required):

- Two replacement bottles and caps/locking rings every 12 months
- One replacement power adapter after the first 12 months
- Twelve valves/membranes (6 sets) every 12 months (1 unit = set of 2)
- One set (2) flanges/breast shields
- One set (2) of tubing
- One hundred breast milk bags every 30 days

Additional supplies above these allowances may be covered with a prescription. The prescription must specify the supplies required in excess of the limits listed above. A supplemental nursing system (SNS) and two sets of nipple shields also may be covered with a prescription.

- In lieu of creating a specific prescription form, the referring provider can complete our **Breast Pump and Supplies Prescription** form and submit it with the claim.
- A certificate of medical necessity is not required unless you exceed the quantity limits listed above.

Breast pumps and supplies can be provided by network or non-network providers or purchased through base commissaries, base/post/station exchanges or any civilian stores (including online retailers) or pharmacies. TRICARE covers standard shipping and handling charges for purchases made online.

## Childbirth and Breastfeeding Support Demonstration

Information on TRICARE's Childbirth and Breastfeeding Support Demonstration (CBSD), which allows certified labor doulas, lactation consultants and lactation counselors to provide reimbursable care to TRICARE beneficiaries can be found on our **Benefits A–Z** web page.

## Lactation Counseling

TRICARE covers lactation or breastfeeding counseling for up to six individual outpatient counseling sessions per birth or adoption when provided as a preventive service separate from an inpatient maternity stay, follow-up outpatient visit or well-child care visit. An approval from HNFS is not required.

TRICARE's CBSD allows for lactation counseling by lactation consultants or counselors not otherwise authorized under TRICARE to provide care.

## Length of Stay

The Newborn's and Mother's Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth. Health plans are prohibited from restricting benefits to stays less than 48 hours after a vaginal delivery or 96 hours following delivery by C-section.

While this law does not apply to the TRICARE program, the TRICARE policy on maternity inpatient stays is consistent with NMHPA. Please be aware that neither the law, nor the TRICARE benefit prevent the patient from being discharged earlier than

48 or 96 hours if both the patient and the provider are in agreement. Conversely, stays beyond the covered 48 or 96 hours may be a covered benefit if deemed medically necessary.

### Midwife Services

Midwife services provided by a certified nurse midwife are a covered benefit. The CNM must be certified by the American Midwifery Certification Board and state licensed when required by the state. Midwife services by a registered nurse who is not a CNM may be covered with a physician referral and supervision. Refer to our **Maternity Care** web page for more information.

### Ultrasounds

Maternity ultrasounds are covered separately from the **maternity care** benefit. TRICARE has specific requirements for covering and reimbursing maternity ultrasound services. For ultrasound coverage details, visit our **Maternity Ultrasounds** page.

**Note:** The professional and technical components of medically necessary fetal ultrasounds are covered outside the maternity global fee.

## Provisional Coverage Program

TRICARE's Provisional Coverage Program provides coverage for emerging treatments and technologies based on review and approval by the Assistant Secretary of Defense for Health Affairs. Benefits under the Provisional Coverage Program include: 3-D mammograms and platelet-rich plasma injections. Additional services may be added. All services and supplies covered under the Provisional Coverage Program require pre-authorization, regardless of the patient's TRICARE plan type. Provisional coverage for an emerging medical treatment or technology may be in effect for not longer than a total of five years. The Assistant Secretary of Defense for Health Affairs, at any time, may terminate the provisional coverage, or modify or terminate the terms and conditions for provisional coverage.

## Telemedicine

Telemedicine (also referred to as telehealth) is the use of information and telecommunications technology to provide medically and psychologically necessary services across distances. Telemedicine services may be used to provide covered TRICARE benefits when such services are medically or psychologically necessary and deemed appropriate medical care. Reimbursement and referral – and/or preauthorization requirements – are the same whether the services are provided in person or via telemedicine.

Telehealth services may be synchronous (two-way audio and video, such as real-time video), asynchronous (one direction at a time, such as submitting medical history from one party to another), or telephonic (audio-only).

Audio-only telehealth can be for provider-to-patient care or for clinical consultations between providers that is specific to a patient's care. Providers should document in the medical records why audio only was chosen in lieu of an audio/video combination. Audio-only telehealth should not be used for care that normally requires a physical examination or a visual evaluation.

- **Exception:** Audio-only services are not allowed under the Autism Care Demonstration. Parent/caregiver guidance performed via telemedicine must be rendered using audio AND video platforms. Learn more on our **ABA Service/ Settings Locations** page.

Telemedicine services do not include texting.

TRICARE will allow a beneficiary to receive telemedicine services at his or her home or other secure location, as long as that location meets the requirements in **TRICARE Policy Manual (TPM)**, Chapter 7, Section 22.1. All Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements apply to telemedicine services. Any audio and video transmissions used must be secured using point-to-point encryption that meets recognized standards.

TRICARE requires providers to:

- Be licensed to practice in the state where the beneficiary is receiving services.
- Implement means for verification of provider and patient identity.
- Establish an alternate plan for communicating with the patient (for example, telephone) in the event of a technological failure.
- Ensure that transmission and storage of data is conducted over a secure network and is compliant with HIPAA requirements.
- Document provider and patient location (city, state, ZIP code) in the medical record as required for the appropriate payment of services.
- Bill with appropriate CPT and Healthcare Common Procedure Coding System (HCPCS) codes and modifiers.
  - For synchronous telemedicine services, use a GT or 95 modifier and place of service that is the location from which the telemedicine visit was rendered. *Example: Place of service 11 is for services rendered from the provider's office.*
  - For asynchronous telemedicine services, use a GQ modifier and place of service that is the location from which the telemedicine visit was rendered. *Example: Place of service 11 if services are rendered from the provider's office.*

***Provider licensing across state lines***

In order to be reimbursed for telehealth under TRICARE, the provider must be a TRICARE-authorized provider and the services rendered must be within the provider's scope of practice under all applicable state(s) law(s) in which services are provided and/or received.

## Exclusions

In general, TRICARE excludes services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or

injury, or for the diagnosis and treatment of pregnancy or well-child care. All services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment, or provided by an unauthorized TRICARE provider, are excluded.

## Complications from Non-Covered Services

Complications from non-covered services are only covered when the initial non-covered treatment was provided in a military hospital or clinic, authorized by the military hospital or clinic Commander and the military hospital or clinic was unable to provide the necessary treatment for the complication. All other treatment of complications, infection from non-TRICARE covered services or removal of non-covered implants are not a covered benefit.

## Exclusions List

The following specific services are excluded under all circumstances. This list is not all-inclusive and is subject to change. Visit the TRICARE **Exclusions** web page for more information.

- Acupuncture
- Alterations to living spaces
- Ambulance services when:
  - Vehicles that provide passenger transport to and from medical appointments (for example, medicabs, ambicabs or paratransit)
  - Ambulance service used instead of taxi service when the beneficiary's condition would have permitted use of regular private transportation
  - Transport or transfer of a beneficiary is of a beneficiary primarily for the purpose of having the patient closer to home, family, friends, or personal physician (with no medical need for the transport); ambulance services related to a condition not covered by TRICARE, such as complications from elective plastic surgery
- Artificial insemination (including in vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies); however, the Defense Health Agency (DHA) Deputy Director may authorize services that are not TRICARE benefits, such as artificial insemination, for ADSMs
- Assisted living facility
- Autopsy services or postmortem examinations
- Aversion therapy
- Biofeedback for treatment of psychosomatic conditions and treatment of hypertension
- Biofeedback equipment for treatment of psychosomatic conditions and treatment of hypertension
- Birth control/contraceptives (non-prescription)
- Bone density studies for routine screening of osteoporosis
- Breast implant removal for autoimmune or connective tissue disorders and for complications resulting from an initial non-covered surgery (for example, elective breast implant)
- Breast MRI (diagnostic) for the following:
  - Evaluation before biopsy
  - Differentiation between benign and malignant breast disease
  - Differentiation between cysts and solid lesions
- Breast MRI (screening) for women considered to be at low or average risk of developing breast cancer
- Camps (for example, for weight loss)
- Cardiac rehabilitation programs (non-hospital based), and Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings
- Care or supplies furnished or prescribed by an immediate family member
- Charges that providers may apply to missed or rescheduled appointments
- Chelation therapy when used to treat cardiovascular disease, peripheral vascular disease, cancer, chronic fatigue syndrome, Alzheimer's disease, multiple sclerosis, autism, attention-deficit/hyperactivity disorder, or any other condition for which chelation therapy is not FDA-approved
- Chronic fatigue syndrome treatment
- Computerized dynamic posturography
- Counseling services that are not medically necessary for the treatment of a diagnosed medical condition (for example, educational, vocational and socioeconomic counseling; stress management; lifestyle modification)
- Clinical trials not sponsored by National Cancer Institute (NCI)
- Costs associated with non-treatment research activities related to clinical trials
- Cranial orthotic device or molding helmet for treatment of nonsynostotic positional plagiocephaly or for the treatment of craniosynostosis before surgery
- Custodial care
- Dental care services and dental X-rays are excluded except authorized adjunctive dental care. (Refer to the *"**Adjunctive Dental Care**"* section in this handbook.)
- Diagnostic admission
- Diapers (incontinence items) under the basic TRICARE benefit (may be covered under the Extended Care Health Option [ECHO])
- Dynamic posturography
- Domiciliary care
- Dyslexia treatment
- Elective supplies or services that are not medically and/or psychologically necessary
- Electrolysis
- Elevators or chairlifts
- Exercise classes in a swimming pool
- Exercise equipment (spas, whirlpools, hot tubs, swimming pools, health club memberships, or other such charges or items)

- Experimental or unproven procedures
- Eyeglasses/contact lenses
  - Adjustments, cleaning and repairs for eyeglasses
  - Replacement of eyeglasses due to loss, wear or physical growth
- Deluxe or extra features for eyeglasses such as mirror coating, polarization or progressive lenses
- Replenishment of disposable contact lenses, after one initial package is cost-shared, when the prescription remains unchanged
- Formulas (for children less than one year of age) that are readily available in a retail environment and are marketed for use by infants without medical conditions
- General exercise programs (even if recommended by a physician and regardless of whether rendered by an authorized provider)
- Gym memberships
- Hair removal
- Home uterine activity monitoring and related services
- Hospice care room and board unless the patient is receiving authorized inpatient or respite level of care
- Hysterectomy when performed solely for the purpose of sterilization and/or hygiene in the absence of pathology
- Inpatient stays
- For rest or rest cures
- To control or detain a runaway child whether or not admission is to an authorized institution
- To perform diagnostic tests, examinations and procedures that could be and are performed routinely on an outpatient basis
- In hospitals or other authorized institutions above the appropriate level required to provide necessary medical care
- Intelligence testing when used:
  - For academic or vocational placement or assessment,
  - To evaluate non-covered disorders (for example, learning disorders), or
  - To assess intelligence without the need to diagnose or plan treatment for a covered psychiatric disorder
- Laser, pulsed light treatment and sclerotherapy to treat spider veins
- Laser/LASIK/refractive corneal surgery except to relieve astigmatism following a corneal transplant
- Learning disability services
- Luxury/convenience equipment or services such as positioning wedges or pillows, flat-free inserts for wheelchair tires and backpacks
- Magnetic resonance neurography
- Manual wheelchairs if TRICARE has already cost-shared a power wheelchair
- Massage therapy
- Maternity ultrasounds that are not medically necessary, including three-and-four-dimensional ultrasounds or to determine the sex of the baby
- Maternity services provided to a TRICARE beneficiary acting as a surrogate without a contractual agreement
- Medications:
  - Drugs prescribed for cosmetic purposes
  - Fluoride preparations
  - Homeopathic and herbal preparations
  - Multivitamins
  - Over-the-counter products (except diabetic supplies)
- Megavitamins and orthomolecular psychiatric therapy
- Midwife services by a lay midwife, certified professional midwife (CPM) or certified midwife (CM)
- Migraine treatment services/procedure such as the following:
  - Occipital nerve stimulation
  - Sphenopalatine ganglion block
  - Histamine desensitization therapy
  - Deep brain neurostimulation
  - Cryoablation of the occipital nerve
  - Spinal cord stimulation
  - Trigger point injections
- Mind expansion and elective psychotherapy
- Mobile Medical Applications (MMAs) and other digital therapeutics unless listed as covered by the TRICARE Program in Chapter 8, Section 2.1
- Monoclonal antibodies for the treatment of mild cognitive impairment and Alzheimer's disease
- National Institutes of Health Clinical Center-rendered care
- Naturopathic care
- Neurofeedback
- Nerve blocks for increasing blood supply to the feet and toes
- Non-medical expenses such as living expenses outside of the hospital including hotels, meals and transportation of an organ donor
- Non-surgical treatment of obesity or morbid obesity
- Orthodontia, such as braces or retainers, is not a covered benefit except when related to the surgical correction of a congenital abnormality such as a cleft palate
- Paternity testing
- Personal, comfort or convenience items (such as beauty and barber services, radio, television, and telephone)
- Positron emission tomography (PET) scans for the following:
  - Malignancies: gastric, initial diagnosis of differentiated thyroid and medullary cell thyroid, and initial diagnosis and monitoring of treatment of colorectal cancer, and diagnosis of renal mass or possible renal cell carcinoma recurrence
  - Alzheimer's disease, frontotemporal dementia and dementia
  - The diagnosis of systemic sarcoidosis

- Physical therapy services for the following:
  - Diathermy, ultrasound and heat treatments for pulmonary conditions
  - General exercise programs
  - Separate charges for instruction of the patient and family in therapy procedures
  - Repetitive exercise to improve gait, maintain strength and endurance and assistive walking, such as that provided in support of feeble or unstable patients
  - Range of motion and passive exercises, which are not related to restoration of a specific loss of function
  - Maintenance therapy that does not require a skilled level of assistance
  - Vocational assessment and training or assessments to determine status of disability
  - Athletic training evaluation (CPT codes 97169-97172)
  - CPT codes 97532 or 97533 when used to improve cognitive function as a result of neuronal growth through the repetitive exercise of neuronal circuits
  - CPT codes 97532 or 97533 for sensory integration training
  - Services provided to address disorders or conditions resulting from occupational deficits
- Postpartum inpatient stays for mothers to stay with newborn infants (usually primarily for the purpose of breastfeeding the infant when the infant, but not the mother, requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother, but not the newborn infant, requires extended postpartum inpatient stay)
- Private hospital rooms unless ordered for medical reasons or because a semiprivate room is not available. Hospitals that are subject to the TRICARE diagnosis-related group (DRG) payment system may provide the beneficiary with a private room but will receive only the standard DRG amount. The hospital may bill the beneficiary for the extra charges if the beneficiary requests a private room.

  A **Request for Non-Covered Services** form should be filled out in this case, in advance of providing the non-covered private room.
- Prosthetics for sports-related purposes (if an initial prosthetic was already cost-shared), exercise equipment or physiotherapy
- Psychiatric treatment for sexual dysfunction
- Pulsed radiofrequency ablation for spinal or back pain
- Radiofrequency denervation for the treatment of thoracic facet pain
- Removal of corns or calluses
- Retirement homes
- Routine foot care (except if required as a result of a diagnosed, systemic medical disease affecting the lower limbs, such as severe diabetes)
- Safety medical supplies such as bath or toilet rails, helmets and childproof locks
- Screening diagnostic tests not related to a specific illness, injury or definitive set of symptoms, except for cancer screening. Refer to preventive services for cancer screening information.
- Self-help courses, except for diabetes self-management training
- Sensory integration therapy
- Services and supplies:
  - Provided under a scientific or medical study, grant or research program for which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor were not TRICARE eligible
  - Furnished without charge (in this case, cannot file claims for services provided free of charge)
  - For the treatment of obesity (such as diets, weight loss counseling, weight loss medications, wiring of the jaw, or similar procedures); for gastric bypass, refer to our **Bariatric (Weight Loss) Surgery** page in **Benefits A–Z**.
  - Inpatient stays directed or agreed to by a court or other governmental agency (unless medically necessary)
  - Occupational disease or injury (for which any benefits are payable under a workers' compensation or similar law, whether such benefits have been applied for or paid, except if benefits provided under these laws are exhausted)
- Services or hospitalizations as a result of a medical or surgical error
- Services/treatment related to the terminal illness (other than hospice care)
- Sex changes or sexual inadequacy treatment, with the exception of treatment of ambiguous genitalia that has been documented to be present at birth
- Shoe inserts; orthopedic shoes except when attached to a brace, arch supports, and other supportive devices for the feet
- Speech therapy services for the following:
  - Myofunctional or tongue-thrust therapy
  - Maintenance therapy that does not require a skilled level of assistance
  - Videofluoroscopy evaluation in speech pathology
  - Services provided to address disorders or conditions resulting from occupational deficits
- Sports physicals
- Subcutaneous implantable estradiol pellets
- Subcutaneous mastectomy for the prevention of breast cancer
- Surgery performed primarily for psychological reasons (such as psychogenic surgery)
- Transcutaneous electrical nerve stimulation (TENS) for treatment of acute, subacute and chronic low back pain

- Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE
- Transplants if the beneficiary has another existing illness that would jeopardize the success of the transplant or if the transplant is not a proven treatment for the beneficiary's condition
- Transportation except by ambulance
- Ultrasounds, use of three-dimensional and four-dimensional rendering and routine screening for breast disease
- Unproven drugs, devices, and medical treatment
- Vision therapy (orthoptics)
- Weight-reduction services/programs, sleeve gastrectomy, repeat or revision procedures due to noncompliance with post-operative nutrition and exercise recommendations
- Wig and hair piece maintenance, supplies, replacement of the wig or hairpiece, hair transplants or any services or supplies for hair regrowth
- Wisdom teeth removal except when the care is indicated in preparation for, or as a result of, dental trauma caused by the medically necessary treatment of an injury or illness
- Work-related or pre-employment physicals

**Note:** Access a current list of non-covered services at TRICARE's **No Government Pay Procedure Code List** page.



# Mental Health Care Services

## Mental Health Care Services

Health Net Federal Services (HNFS) manages the TRICARE mental health care benefit and provider network in the TRICARE West Region (West Region). HNFS reviews clinical information provided to determine if mental health care is medically or psychologically necessary.

This section is not all inclusive and services listed as TRICARE-covered services are subject to change. For additional benefit details and the most up-to-date information about TRICARE-covered services, visit **Benefits A–Z** at **www.tricare-west.com**.

Please refer to **www.tricare-west.com** for up-to-date information.

## Mental Health Care Providers

TRICARE covers services delivered by qualified, TRICARE-authorized mental health care providers practicing within the scope of their licenses, to diagnose and/or treat covered mental health disorders. Beneficiaries are encouraged to receive mental health care at military hospitals or clinics. However, beneficiaries may be referred to network providers if military hospital or clinic care is unavailable.

The TRICARE mental health care outpatient network consists of TRICARE-authorized providers, such as psychiatrists and other physicians, clinical psychologists, certified psychiatric nurse specialists (CPNS), certified clinical social workers, TRICARE-certified mental health counselors (TCMHC)®, certified marriage and family therapists, supervised licensed pastoral counselors, supervised mental health counselors (SMHC), licensed psychological associates, Board Certified Behavior Analysts® (BCBA®), Board Certified Behavior Analysts – Doctoral® (BCBA-D®), and applied behavior analysis (ABA) licensed/certified providers. The TRICARE mental health care inpatient network consists of hospitals, inpatient psychiatric units, partial hospitalization programs (PHP), intensive outpatient programs (IOP), residential treatment centers (RTC), and substance use disorder rehabilitation facilities (SUDRF). TRICARE-authorized providers must meet specific licensing and certification requirements and be certified by TRICARE to provide care under the TRICARE program. According to federal regulations governing the TRICARE program (**Title 32, Code of Federal Regulations [CFR], Part 199, § 199.6**), individual providers must currently be licensed in the jurisdiction in which the provider renders professional health care services to TRICARE beneficiaries.

**Note for telehealth:** In order to be reimbursed for telehealth under TRICARE, the provider must be a TRICARE-authorized provider and the services rendered must be within the provider's scope of practice under all applicable state(s) law(s) in which services are provided and/or received.

All TRICARE-authorized mental health care providers are required to be licensed as independent of supervision at the highest available level by the applicable jurisdiction for their specific provider type, with the exception of. SMHCs are required by TRICARE policy to provide services under the supervision of a physician.

When a jurisdiction does not offer an individual professional license, certification by a qualified accreditation organization, as defined in **Title 32, CFR, Part 199, § 199.2**, is required (exception for licensed professional counselors and mental health counselors: TRICARE has specific requirements for these provider types to practice independently).

- Licensing or certification must be at the full clinical practice level, independent of supervision or physician oversight. Individual health care professionals who only render health care services under direct and ongoing supervision are excluded from TRICARE-authorized provider status.
- Per federal regulation, the Director, Defense Health Agency (DHA) may establish specific provider education, training and experience requirements to ensure care is provided by fully qualified individuals. In some cases, these requirements may exceed those required by state licensure boards or certifying bodies. Current requirements set by the Director, DHA, distinguish between SMHCs and TCMHCs, even when providers are licensed for full independent clinical practice by their respective jurisdictions.

Freestanding PHPs, IOPs, RTCs and SUDRFs must be TRICARE-authorized and sign participation agreements to comply with all TRICARE policies prior to rendering services to TRICARE beneficiaries.

**Note for RTCs:** An RTC shall be currently accredited by The Joint Commission (TJC); the Commission on Accreditation of Rehabilitation Facilities (CARF); the Council on Accreditation (CoA); or an accrediting organization approved by the Director, DHA. The RTC must be licensed as an RTC to provide RTC services within the applicable jurisdiction in which it operates.

A TRICARE-authorized psychiatric PHP and IOP can be a distinct part of an otherwise TRICARE-authorized institutional provider or a freestanding program. For TRICARE certification:

- **Acute care hospital-based PHPs and IOPs** – When a hospital is a TRICARE-authorized provider, the hospital's PHP and IOP also shall be considered a TRICARE-authorized provider.
- **Freestanding PHPs and IOPs** – Must be currently accredited by The TJC, the CARF or the CoA.

Additional information about federal regulation pertaining to TRICARE providers can be found at **https://manuals.health.mil/**.

TRICARE policy requirements for specific provider types may be found in the TRICARE Policy Manual (TPM) at **https://manuals.health.mil/**.

**Mental health care services provided by mental health counselors or professional counselors require a physician's documented referral and supervision (a physician is defined as a doctor of medicine [MD] or a doctor of osteopathic medicine [DO]).*

### Accessing Mental Health Care Services

TRICARE beneficiaries are encouraged to receive mental health care services at military hospitals and clinics whenever possible. TRICARE covers services delivered by qualified, TRICARE-authorized (network and non-network) mental health care providers practicing within the scopes of their licenses, to diagnose or treat covered mental health disorders.

### Locating Mental Health Care Providers

HNFS assists all TRICARE beneficiaries with locating TRICARE network mental health care providers. Beneficiaries and providers can use the online **Network Provider Directory** or call **1-844-866-WEST (1-844-866-9378)** 24 hours a day, 7 days per week, 365 days per year for assistance with locating a mental health care provider.

### Court-Ordered Care

Court-ordered care is defined by TRICARE as outpatient and inpatient medical services that a party in a legal proceeding is ordered or directed to obtain by a court of law. All TRICARE requirements, limitations and policies apply to court-ordered mental health care. As in any situation, TRICARE benefits are paid only if the services are medically or psychologically necessary to diagnose and/or treat a covered condition. The services must be at the appropriate level of care to treat the condition, and the beneficiary (or family) must have a legal obligation to pay for the services.

## Pre-Authorization and Referral Requirements

TRICARE pre-authorization and referral requirements vary according to beneficiary type, program option, diagnosis, and type of care. General pre-authorization and referral requirements include:

- **Emergency mental health care** – Emergency mental health care does not require pre-authorization. However, if admitted, the facility must contact HNFS within 24 hours of the admission or on the next business day to obtain pre-authorization for a continued stay.
- **Outpatient mental health care for active duty service members (ADSM)** – ADSMs should receive mental health care at a military hospital or clinic whenever possible. ADSMs must have pre-authorizations and/or referrals from their primary care managers (PCM) and HNFS before seeking non-emergency mental health care.
- **Outpatient mental health care for non-ADSMs** – TRICARE Prime beneficiaries (excluding ADSMs) do not require an approval from HNFS when seeing a network provider. TRICARE Prime beneficiaries must have an approval from HNFS to get care from a non-network provider unless they choose to use their **point-of-service** option. TRICARE Select beneficiaries do not require an approval from HNFS.

  **Exception** – Beneficiaries must have a referral (or an authorization if no referral on file) for the following outpatient mental health care services:
  - Transcranial magnetic stimulation (TMS) for beneficiaries aged 18 years or older who have a diagnosis of depressive disorder (**Letter of Attestation** available)
  - Electroconvulsive therapy (ECT) (**Letter of Attestation** available)
  - Spravato® (Esketamine) (**Letter of Attestation** available)
  - IOPs
  - PHPs
  - Psychoanalysis
- **Non-emergency inpatient mental health care** – For all TRICARE beneficiary categories, including ADSMs (except TRICARE For Life [TFL] beneficiaries), all non-emergency inpatient care requires pre-authorization.

**Note for TFL beneficiaries:** TFL beneficiaries should follow Medicare rules when seeking mental health care. If TRICARE is the primary payer (for example, for services Medicare does not cover, if Medicare benefits are exhausted), beneficiaries should follow TRICARE pre-authorization and referral requirements as stated for TRICARE Select beneficiaries above. For more information about TFL, contact Wisconsin Physicians Service – Military and Veterans Health (WPS) at **www.tricare4u.com** or call **1-866-773-0404**.

### Obtaining Pre-Authorizations and Referrals

Visit **www.tricare-west.com** to determine current requirements and to submit pre-authorization and referral requests for mental health care services. Refer to the ***Health Care Management Administration*** section of this handbook for more information about pre-authorization and referral requirements.

**Note:** Per the **TRICARE Reimbursement Manual (TRM)**, Chapter 1, network and non-network providers, who submit claims for services without obtaining a pre-authorization when required, will receive a 10% payment reduction during claims processing. For a network provider, the penalty may be more than 10%, depending on whether his or her network contract includes a higher penalty. These payment reduction penalties cannot be passed on to the beneficiary for payment. It is the provider's responsibility to obtain pre-authorization when required.

*Spravato® is a registered trademark of Janssen Pharmaceuticals Inc.*

## Clinical Documentation for Mental Health Care Services

TRICARE providers are required to keep sufficient clinical records to substantiate that care provided was actually and appropriately furnished and medically or psychologically necessary. The following mental health care provider types must, at a minimum, maintain medical records in accordance with TJC; CARF; CoA; or an accrediting organization approved by the Director, DHA.

- Acute care psychiatric hospitals
- IOPs
- SUDRFs
- Opioid treatment program (OTP)
- Outpatient mental health and SUD treatment and PHPs
- Psychiatric RTCs
- Psychiatric units within acute care institutions

Clinical documentation should include, but is not limited to, psychiatric and psychological evaluations, physician orders, treatment plans, physician and/or integrated progress notes, and discharge summaries (refer to **TRICARE Operations Manual** [**TOM**], Appendix A, Definitions for more information).

### Standardized Measures

In addition, across all mental health care settings (outpatient mental health care and SUD treatment, OTPs, IOPs, PHPs, psychiatric RTCs, psychiatric hospitals, and inpatient/residential SUDRFs), the evaluation report must include assessments using standardized measures for the diagnosis of post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD) and major depressive disorder (MDD).

The required standardized measures, to be performed at treatment baseline, 60-120 days intervals and at discharge, include:

- PTSD Checklist (PCL)
- GAD-7 and
- MDD: Patient Health Questionnaire – 8 (PHQ-8)

Providers must notify the referring military hospital or clinic when a TRICARE beneficiary, in the provider's clinical judgment, meets any of the following criteria:

- Is a potential harm to self, others or mission,
- Is admitted or being discharged from any inpatient mental health or SUDRF,
- Is experiencing an acute medical condition or involved in treatment that interferes with duty, and/or
- Has entered into or is being discharged from a SUD program.

## Outpatient Services

TRICARE covers medically or psychologically necessary outpatient mental health care services, including outpatient psychotherapy, psychological testing and assessment, medication management, ECT, TMS, and Spravato®. Outpatient mental health services, regardless of length/quantity, may be covered as long as the care is considered medically or psychologically necessary and appropriate.

### Electroconvulsive Therapy

TRICARE may cover medically necessary ECT rendered by a qualified provider. However, using ECT as negative reinforcement (aversion therapy) is not covered.

### Family Therapy

Family therapy is considered outpatient psychotherapy and a TRICARE-covered benefit when determined to be medically or psychologically necessary for treatment of a diagnosed mental health disorder. Family therapy may involve all or a portion of the family.The family generally includes the spouse of the beneficiary with the mental health disorder; his/her children; or, in the case of a child beneficiary, the parents, stepparents, guardians, and siblings. When it is determined appropriate, other family members also could be included.

**Note:** Except for services authorized under Military OneSource, ADSMs must have a referral from their PCM for all civilian mental health care services prior to the services being rendered by a TRICARE-authorized provider.

Additional resources for marriage counseling and family therapy include:

- **Military OneSource** – Offers cost-free, confidential counseling sessions to eligible military personnel and their family members. Counseling is available in person or by phone and addresses short-term issues, such as grief and loss, deployment adjustment, work/life management, and combat stress. Visit the **Military OneSource** website or call **1-800-342-9647**.

- **Military & Family Life Counselors (MFLCs)** – Provide direct, face-to-face, non-medical counseling and education regarding daily life stressors related to deployment and reintegration. The counselors address concerns of stress, relationships, family problems, financial issues, grief and loss, conflict resolution, and the emotional challenges of reintegrating into a non-combat environment. Visit **Military OneSource** for more information.
- **Local military hospitals or clinics** – Beneficiaries can check with their local military hospitals or clinics to see if marriage counseling is a benefit offered through those facilities. Chaplain services also are available at most military bases.
- **Community-based services** – Beneficiaries can check their communities to see if any city-, county- or state-sponsored mental health care services, social service agencies, community groups, chaplains, or church-based couples/ family services are available in the area.

## Gender Dysphoria Treatment

Gender dysphoria (GD) is a condition where for at least a six-month duration a person experiences clinically significant distress or impairment in social, occupational or other important areas of functioning because of a marked incongruence between the gender assigned (usually at birth) and their experienced/expressed gender identity. Non-surgical treatment for gender dysphoria, to include psychotherapy, pharmacotherapy and hormone treatments are a limited benefit. All services and supplies related to surgical treatment for gender dysphoria are not covered benefits. *Exception: ADSMs may be eligible for gender-affirming surgery evaluations under a blanket **Supplemental Health Care Program** waiver.* Referral and pre-authorization requirements apply based on the type of treatment the beneficiary receives.

## Intensive Outpatient Programs

An IOP for mental health care is a covered benefit when the care is medically and psychologically necessary and appropriate. An IOP typically consists of six to nine or more hours of services a week (minimum of two hours per treatment day) that includes an assessment, treatment and rehabilitation for individuals requiring a lower level of care than a PHP, RTC or acute inpatient psychiatric hospitalization.

## Medication Management

Psychotropic pharmacologic (medication) management is a covered benefit. When provided in conjunction with a psychotherapy visit, reimbursement for medication management is included in the allowable charge for psychotherapy. Any provider practicing within the scope of a state license may prescribe psychotropic medications as part of an office visit. However, all patients receiving psychotropic medication must be under the care of a qualified mental health care provider authorized by state licensure to prescribe drugs. View our billing guidelines to learn more about psychotropic medication management.

Find additional information on medication assisted treatment (MAT) in the ***Substance Use Disorder Treatment Services/ Opioid Treatment Programs*** sections below.

For more information about mental health care medication management, refer to the **TRICARE Policy Manual** (**TPM**), Chapter 7.

## Outpatient Psychotherapy

Outpatient mental health care (psychotherapy) that is medically or psychologically necessary to treat a covered mental health disorder is a covered benefit. This includes any combination of individual, family, collateral, or group sessions.

Outpatient mental health care therapy includes visits with a supervised licensed pastoral counselor, supervised licensed professional counselor or SMHC, must be referred or ordered and supervised by a physician (MD or DO).

**Note:** When multiple sessions of the same type are conducted on the same day (for example, two individual sessions or two group sessions), only one session is reimbursed. A collateral session may be conducted on the same day the beneficiary receives individual therapy.

## Partial Hospitalization Programs

PHPs for mental health care are a covered benefit. Services may include day, evening, night, and weekend treatment programs that employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. PHP is a time-limited ambulatory and active treatment program that offers therapeutically intensive, coordinated and structured clinical services within a stable therapeutic environment.

PHP is an appropriate setting for crisis stabilization, treatment of partially stabilized mental disorders to include SUDs (refer to "***Substance Use Disorder***" section of this handbook) – and transitioning from an inpatient program when medically necessary. Office-based PHP is not a covered benefit.

A psychiatrist employed by the PHP must provide general direction to ensure treatment meets both emotional and physical needs. A primary or attending TRICARE-authorized mental health care provider only may render care that is part of the PHP treatment plan.

For information about submitting PHP claims, reference the ***TRICARE Reimbursement Methodologies*** section of this handbook.

## Psychological Testing and Assessment

Psychological testing and assessment is a covered benefit when medically or psychologically necessary and provided in conjunction with otherwise covered psychotherapy or as a required part of the assessment and reassessment process for ABA services.

Psychological testing is not covered when used to assess for academic placement related to education programs or issues or deficiencies, or if the sole basis for testing is assessing for a

learning disability. Testing is not covered to diagnose specific learning disorders or disabilities (for example, reading disorder or dyslexia, mathematic disorder, disorder of written expression, and disorders not otherwise specified). Refer to **TPM**, Chapter 7, Section 3.10.

### Spravato®

Spravato®, also known as esketamine, nasal spray is a limited benefit for treatment-resistant depression in beneficiaries aged 18 years and older. An approval from HNFS is required for all beneficiaries. Ketamine administered through subcutaneous, sublingual, IV, injectable, nasal spray, or orally is not a covered benefit. TRICARE follows the Centers for Medicare & Medicaid Services' (CMS) billing guidelines for Spravato, which specify use of HCPCS codes G2082-G2083 rather than E/M codes.

### Transcranial Magnetic Stimulation

TRICARE may cover medically necessary TMS rendered by a qualified provider. The beneficiary must be aged 18 years or older and have a diagnosis of depressive disorder.

## Inpatient Services

Non-emergency inpatient admissions may require pre-authorization from HNFS. Verify requirements at **www.tricare-west.com**.

### Acute Inpatient Mental Health Care

Inpatient mental health care services, regardless of length/quantity, may be covered as long as the care is considered medically or psychologically necessary and appropriate.

### Follow-Up Mental Health Care After Inpatient Stays

The National Committee for Quality Assurance (NCQA) includes outpatient mental health follow-up care for patients hospitalized with a mental health condition as one of its Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Timely follow-up care may help lower rates of rehospitalization and ease beneficiaries' transitions into their communities. If you are a mental health care provider contacted by a local hospital or HNFS regarding a beneficiary who is discharging from a psychiatric hospitalization, we ask that you schedule a follow-up appointment with the beneficiary within seven days after discharge. If you are a PCM and receive a call from a beneficiary who recently had a psychiatric inpatient hospitalization, encourage the beneficiary to see a mental health care provider within seven days after having been discharged.

### Residential Treatment Center Care

RTC care provides extended care for children and adolescents with psychological disorders who require continued treatment in a therapeutic environment. The provider and family must submit documentation with the request, and the mental health disorder must meet clinical review criteria before admission can be authorized. Family and provider applications are located at **www.tricare-west.com**.

***Guidelines***

- Elective (non-emergency), requires pre-authorization from HNFS.
- The family and/or guardian should actively participate in the continuing care of the beneficiary through either direct involvement at the facility or geographically distant family therapy unless therapeutically contraindicated.
- Admission primarily for SUD rehabilitation is not authorized.
- A TRICARE-authorized mental health care provider must recommend and direct care.

***Coverage limits***

RTC care is only covered for beneficiaries up to age 21.

**Note:** HNFS may approve additional RTC hours on a case-by-case basis. TRICARE reimburses RTC care at an all-inclusive per diem rate.

The only three charges considered outside the all-inclusive RTC rate are:

- **Geographically distant family therapy** – The family therapist may bill and be reimbursed separately from the RTC if therapy is provided to one or both of the child's parents/guardians residing a minimum of 250 miles from the RTC.
- **RTC educational services** – Educational services are covered only when local, state or federal governments cannot provide appropriate education. TRICARE is always the last payer. For network providers, this limitation applies only if educational services are not part of the contracted per diem rate.
- **Non-mental health care services** – These services (for example, medical treatments for asthma or diabetes) are reimbursed separately.

## Substance Use Disorder Services

SUD treatment in the following circumstances may be a covered benefit:

- **Acute inpatient care:** Treatment for complications of alcohol and drug abuse or dependency and detoxification is covered only when the patient's condition is such that a hospital setting is required. Pre-authorization is not required; however, HNFS requires notification of inpatient facility admissions and discharge dates by the next business day following the admission and discharge.
- **Rehabilitation:** Pre-authorization is required for all beneficiaries receiving care at an inpatient facility.
- **Outpatient services:** Individual, group and family therapy; MAT; and office-based opioid treatment are covered by an individual provider, or at a certified hospital or SUDRF. TRICARE Prime beneficiaries (excluding ADSMs) do not require an approval from HNFS when seeing a network provider. TRICARE Prime beneficiaries must have an approval from HNFS to see a non-network provider unless they choose to use their **point-of-service** option. TRICARE Select beneficiaries do not require an approval from HNFS.

**Exception –** Beneficiaries must have a referral (or an authorization if no referral on file) for the following outpatient SUD services:

- IOPs
- PHPs

### Opioid Treatment Programs

An opioid treatment program (OTP) is any treatment program, either freestanding or hospital based, certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) that adheres to Department of Health and Human Services' regulations detailed in **Title 42, CFR, Part 8**, to provide supervised assessment and MAT for patients who are opioid addicted. Treatment in OTPs provides a comprehensive, individually tailored program of medication therapy integrated with psychosocial and medical treatment and support services that address factors affecting each patient. Treatment in OTPs can include management of opiod withdrawal symptoms (detoxification) and medically supervised withdrawal from maintenance medications. MAT – a combination of pharmacotherapy, medical treatment and individually tailored psychosocial treatment and support services – is a TRICARE-covered benefit provided in OTPs by TRICARE-authorized providers when medically and psychologically necessary.

### Substance Use Disorder Intensive Outpatient Programs

An IOP for chemical dependency is a covered benefit when the care is medically and psychologically necessary and appropriate. An IOP typically consists of six to nine or more hours of services a week (minimum of two hours per treatment day) that includes assessment, treatment and rehabilitation for individuals requiring a lower level of care than a PHP, inpatient/residential SUDRF care or acute inpatient psychiatric or chemical dependency hospitalization.

### Substance Use Disorder Partial Hospitalization Programs

PHPs for SUDs are a covered benefit. Services may include day, evening, night, and weekend treatment programs that employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. PHP is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. PHP is an appropriate setting for crisis stabilization, treatment of partially stabilized mental disorders (see ***Partial Hospitalization Programs*** section) – to include substance use disorders – and a transition from an inpatient program when medically necessary.

A licensed TRICARE-authorized physician employed by the PHP must provide general direction to ensure treatment meets both emotional and physical needs. A primary or attending TRICARE-authorized mental health care provider only may render care that is part of the PHP treatment plan. For information about submitting PHP claims, see the ***TRICARE Reimbursement Methodologies*** section of this handbook.

## Telemental Health Care

Telemental health care services provide medically and psychologically necessary services through secure audio and video conferencing via webcam from a secure location, as long as that location meets the requirements detailed in **TPM**, Chapter 7, Section 22.1. Telemental health care services are subject to the same requirements, criteria and limitations that apply to medical and psychological services. Refer to the ***Covered Services*** section of the handbook and also the **Benefits A–Z** at **www.tricare-west.com**.

HNFS has partnered with several companies to offer **telehealth services**, including telemental health care services, to West Region beneficiaries.

**Note:** HNFS' telehealth partners are subject to change.

***Provider licensing across state lines***

In order to be reimbursed for telehealth under TRICARE, the provider must be a TRICARE-authorized provider and the services rendered must be within the provider's scope of practice under all applicable state(s) law(s) in which services are provided and/or received.

## Non-Covered Mental Health Care Services

The following mental health care services are not covered under TRICARE. This list is not all-inclusive.

- Aversion therapy (including electric shock and the use of chemicals for alcoholism, except for Antabuse® [disulfiram], which is covered for the treatment of alcoholism)
- Mental health care services and supplies related solely to obesity and/or weight reduction
- Bioenergetic therapy
- Biofeedback for psychosomatic conditions
- Carbon dioxide therapy
- Counseling services that are not medically necessary in the treatment of a diagnosed medical condition (for example, educational counseling, vocational counseling, nutritional counseling, stress management, marital therapy, or lifestyle modifications)
- Custodial nursing care
- Diagnostic admissions
- Educational programs
- Environmental ecological treatments
- Experimental procedures
- Filial therapy
- Guided imagery
- Hemodialysis for schizophrenia
- Marathon therapy
- Megavitamin or orthomolecular therapy

- Microcurrent electrical therapy (MET), cranial electrotherapy stimulation (CES) or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression, insomnia, or PTSD and electrical stimulation devices used to apply this therapy
- Narcotherapy with lysergic acid diethylamide (LSD)
- Primal therapy
- Psychosurgery (surgery for the relief of movement disorder and surgery to interrupt the transmission of pain along sensory pathways are not considered psychosurgery)
- Rolfing
- Sedative action electrostimulation therapy
- Services and supplies that are not medically or psychologically necessary for the diagnosis and treatment of a covered condition
- Services of V-code diagnosis or Z-code in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
- Sexual dysfunction therapy
- Surgery performed primarily for psychological reasons (for example, psychogenic)
- Telephone counseling (except for geographically distant family therapy related to RTC treatment)
- Therapy for developmental disorders, such as dyslexia, developmental mathematics disorders, developmental language disorders, and developmental articulation disorders
- Training analysis
- Transcendental meditation
- Treatment for sexual perpetrators or predators
- Unproven drugs, devices and medical treatments or procedures
- Vagus nerve stimulation therapy
- Z therapy

*Antabuse is a registered trademark of Teva Women's Health, Inc.*


## Sexual Disorders

Sexual dysfunction is characterized by disturbances in sexual desire and by the psychophysiological changes that characterize the sexual response cycle, causing marked distress and interpersonal difficulties. Any therapy, service or supply provided in connection with sexual dysfunction or inadequacies is excluded from TRICARE coverage.

Exclusions include therapy, services or supplies for these disorders/dysfunctions:

- Orgasmic disorders (for example, female orgasmic disorder, male orgasmic disorder, premature ejaculation)
- Paraphilias (for example, exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism, and paraphilia not otherwise specified)
- Sexual arousal disorders (for example, female sexual arousal disorder, male erectile disorder)
- Sexual desire disorders (for example, hypoactive sexual desire disorder, sexual aversion disorder)
- Sexual dysfunction due to a general medical condition
- Sexual dysfunctions not otherwise specified (including those with organic or psychogenic origins)
- Sexual pain disorders (for example, dyspareunia, vaginismus)
- Substance-induced sexual dysfunction

# Health Care Management and Administration

## Advance Directives

Hospitals and other health care providers are required under the federal Patient Self-Determination Act to give patients information about their rights to make their own health care decisions, including the right to accept or refuse medical treatment. The term "advance directive" can describe a variety of documents used to indicate a patient's requests regarding medical care. Living will and health care power of attorney documents are types of advance directives. Some states also have a document specifically called an Advance Health Care Directive. Advance directive may be used to refer to any of these specific documents or all of them in general.

States differ widely on the types of advance directives they officially recognize. Some states also require patients use a specific advanced directive form. Please inform your patients about advance directives and advise them to contact an attorney who is familiar with the beneficiary's state statutes regarding advance directives if there are questions or concerns.

## Network Utilization

Military hospital and clinic or TRICARE civilian network providers should be the first option in TRICARE beneficiary care. In most cases, care can be arranged at a military hospital or clinic or through the civilian provider network while meeting TRICARE **access-to-care standards**. TRICARE network and non-network participating providers are expected to refer TRICARE Prime (TRICARE Prime Remote [TPR], TRICARE Young Adult [TYA] Prime) beneficiaries to TRICARE network providers, except in an emergency or where the provider has obtained a referral or pre-authorization. Failure to do so could result in the provider being held financially responsible for the costs incurred in connection with the unauthorized services and/or non-covered services, including (but not limited to) beneficiary point-of-service fees.

If TRICARE Prime beneficiaries choose to receive TRICARE-covered services from non-network providers without referrals from their primary care managers (PCM) or Health Net Federal Services (HNFS), these services will be covered under the beneficiary's **point-of-service** option. The **point-of-service** option does not apply to active duty service members (ADSM). ADSMs who do not coordinate care through their PCMs may be responsible for the entire cost of care.

All TRICARE Prime requests for a pre-authorization or referral to a non-network provider must include specific medical necessity and justifying information as to why a non-network provider must be used in lieu of a TRICARE network provider. The **Network Provider Directory** is located at **www.tricare-west.com**.

TRICARE Select beneficiaries can realize cost savings and expanded preventive services benefits when choosing to receive care from network providers.

## Referral Process

Referrals are for services not considered primary care (for example a PCM sends a patient to see a cardiologist to evaluate a possible heart problem).

The referral may be either:

**Evaluation only** – These referrals are for the initial office visit evaluation of the patient, including required diagnostic services, but not treatment. This type of referral also includes requests for second opinions.

**Evaluation and treatment** – These referrals are for the initial office visit evaluation, required diagnostic services and treatment related to a specific medical condition.

Refer to the **Prior Authorization, Referral and Benefit Tool** for additional diagnostic service requirements.

### Referral Requirements by Beneficiary Category

Certain types of TRICARE beneficiaries may require a referral from HNFS for specialty care. Providers can use the **Prior Authorization, Referral and Benefit Tool** to determine if an HNFS referral is required.

For most specialty services, TRICARE Prime (TRICARE Prime, TPR, TYA Prime) beneficiaries must have a referral from their PCMs before seeking care from other professional or individual paramedical providers. In addition to a PCM referral, there are some services that require pre-authorization.

Refer to "***TRICARE Prime and TRICARE Prime Remote Point-of-Service Option***" in the ***Eligibility*** section for information on the **point-of-service** option available to beneficiaries who are enrolled in TRICARE Prime plans.

Important things to remember about referrals:

- The beneficiary may be directed to receive care at a military hospital or clinic. This is referred to as the right of first refusal or ROFR. HNFS will confirm if the military hospital or clinic offers the specialty service being requested and determine the military hospital's or clinic's ability to accept the beneficiary for care. If care cannot be provided, HNFS will authorize care within the civilian network.
  - TRICARE Prime beneficiaries must see TRICARE network providers when available to avoid additional costs.
  - The **point-of-service** option allows TRICARE Prime beneficiaries to self-refer to any TRICARE network or non-network provider for TRICARE-covered services without referrals from their PCMs or HNFS. Beneficiaries who use this option will pay a deductible and have higher cost-shares for services. For **point-of-service** cost information, visit **www.tricare-west.com**. ADSMs who do not coordinate care through their PCMs may be responsible for the entire cost of care.
  - Under the TPR option, the Specified Authorization Staff (SAS), PCM and HNFS will coordinate the arrangements for all required military examinations for ADSMs. Civilian PCMs must contact HNFS to initiate the referral process.
    - The SAS will provide the protocol, procedures and required documentation through HNFS to the provider performing the examination.
    - The SAS also will review requests for specialty and inpatient care to determine the impact on fitness- for-duty and whether the ADSM will receive related fitness-for-duty care at a military hospital or clinic or with a network provider.

## Coordinating a Second Opinion

Beneficiaries may contact their PCMs or providers to schedule an appointment for a second opinion. The beneficiary has a right to request an office visit with another provider for a second opinion. HNFS must approve second opinions for TRICARE Prime beneficiaries.

When approved, second-opinion requests cover the initial evaluation, one follow-up visit and diagnostic services (any necessary lab work, X-rays or testing) but not treatment. The approval will be valid for a specific length of time as stated on the approval letter. Additional services for a beneficiary with an active HNFS approval for the current episode of care will not be approved by HNFS without an approval from the beneficiary's PCM or referring specialist.

## Changing a Provider on a Referral

Beneficiaries who would like to change the approved provider on a referral can do so through the Authorization Status tool at **www.tricare-west.com** (login required) or by contacting HNFS to determine if a provider change is possible. However, if a beneficiary seeks care from the provider specified on an approved referral and then wishes to change to another provider, a new HNFS approval will be required.

There are times when a provider change cannot be made. For example, a TRICARE Prime beneficiary is required to seek services from a military hospital or clinic or a network provider when one is available within access-to-care standards.

**Note:** The determination to refer to a network provider when one is available is not an appealable issue. If the beneficiary chooses to see a non-network provider when he or she has been directed to a network provider, the beneficiary will be using the **point-of-service** option.

## Fetal Surgery Referral Line

Pregnant TRICARE beneficiaries who have a fetal condition or suspected fetal condition and their providers have access to a dedicated call center option to request an expedited referral for fetal surgery. Call the HNFS Case/Care Support line at **1-844-524-3578** between 9 a.m.–6 p.m. (local time) and choose option 4 for maternity fetal support.

## Referral Review Guidelines

The PCM's primary goal is to help beneficiaries achieve optimal health through straightforward, low-complexity decision making and appropriate application of diagnostic technology and therapeutic procedures. The PCM is responsible for his or her patients' health care, with the exception of emergency circumstances or a medical condition that requires a specialist's consultation or treatment. In the event a patient requires care from one or more specialists, the PCM is responsible for coordinating all services rendered.

HNFS and TRICARE expect the PCM to perform the following primary care services:

- Most preventive services (the beneficiary can receive preventive services from other network providers)
- Management of minor illness or injury
- Minor mental health counseling
- Management of stable chronic conditions
- Decision making that is straightforward or of low complexity
- Encouragement to use military hospital or clinic pharmacies or TRICARE Pharmacy Home Delivery

The PCM may refer patients only when a specialist's consultation and complex decision making are required.

## Clear and Legible Reports/Consultation Reports

Please refer to "***Section 2***" of this handbook.

# Pre-Authorization Process

Pre-authorizations are for certain services and/or procedures that require HNFS review and approval before services or procedures are provided. Some services and/or procedures that require pre-authorization include certain mental health care, hospitalization, surgical, and therapeutic procedures.

## Pre-Authorization Requirements

Providers can use HNFS' online **Prior Authorization, Referral and Benefit Tool** to determine if an approval from HNFS is required.

Requirements are subject to change as a result of TRICARE program modifications and/or during annual requirement reviews in accordance with HNFS' TRICARE Department of Defense (DOD) contract. Pre-authorization requirements are reviewed annually in accordance with HNFS and TRICARE policy to evaluate medical and mental health care trends and to better control health care costs for the government.

When requesting a pre-authorization, the beneficiary may be directed to receive care at a military hospital or clinic. HNFS will confirm if a military hospital or clinic offers the specialty service being requested and determine if the military hospital or clinic has the ability to accept the beneficiary for care. If a military hospital or clinic cannot provide care, HNFS will arrange for services within the civilian network.

Per the **TRICARE Reimbursement Manual (TRM)**, Chapter 1, network and non-network providers, who submit claims for services without obtaining a pre-authorization when required, will receive a 10% payment reduction during claims processing. For a network provider, the penalty may be greater than 10% depending on whether his or her network contract includes a higher penalty. These payment reduction penalties cannot be passed on to the beneficiary for payment. It is the provider's responsibility to obtain pre-authorization when required.

If after visiting our website you are still unsure of pre-authorization or referral requirements, you may submit a request online at **www.tricare-west.com** to determine if the service is covered under TRICARE.

## When are both a pre-authorization and referral required?

Both a pre-authorization and a referral are required when a TRICARE Prime beneficiary receives a referral to a specialist and the specialist wants to perform a service on the pre-authorization list. For example, a beneficiary needing general surgery. The PCM would submit a referral to see a general surgeon and the surgeon would request pre-authorization for the surgery.

## Inpatient Notification Process

HNFS requires notification of all inpatient facility admissions and discharge dates by the next business day following the admission and discharge. HNFS will conduct continued stay reviews for all mental health care and other services. The medical facility will receive an authorization number after HNFS receives clinical information and the discharge date. Clinical records will be requested as necessary. To ensure that military hospitals and clinics have insight into care being delivered in civilian hospitals, clinical records should be submitted online at **www.tricare-west.com** or faxed to **1-844-818-9289** prior to the beneficiary being discharged.

## Letters of Attestation

TRICARE coverage of certain limited benefits is subject to specific clinical criteria. When requesting pre-authorization for some of these services, a letter of attestation (LOA) can be submitted by the provider in lieu of additional clinical documentation. The provider must complete the beneficiary information, provide the diagnosis and medical necessity rationale for the requested services or supplies and then sign the letter to attest to the accuracy of the clinical information.

This letter must then be submitted along with a pre-authorization request. An LOA is not available for all services. Visit our **Letters of Attestation** page for further information.

## Emergency Admission

TRICARE providers must notify HNFS of an emergency room inpatient admission and discharge date within 24 hours or by the next business day following admission and discharge. Fax the patient's hospital admission record face sheet to HNFS at **1-844-818-9289**. The hospital admission record face sheet should include the beneficiary's demographic information – including sponsor Social Security number (SSN) or DOD Benefits Number (DBN), health plan information, name of the admitting physician, and admitting diagnosis and date. If the hospital admission record face sheet is not available, providers can submit the information online at **www.tricare-west.com**. Be sure to note that the information is for an emergency inpatient admission notification.

HNFS reviews admission information and authorizes continued care, if necessary. Refer to the "***Medical Coverage***" section of this handbook for more information on urgent care and emergency services.

## Submitting Pre-Authorization and Referral Requests

Submit pre-authorization and referral requests to HNFS online at **www.tricare-west.com**. HNFS offers two online submission tools: CareAffiliate (requires login) and the Web Authorization Referral Form (does not require login.)

If an LOA is required, please attach it to your request (using CareAffiliate). HNFS will notify you and provide instructions if additional documentation is needed to process your request.

**Note:** Military hospital and clinic providers should follow procedures for pre-authorizations within the military hospital or clinic. For care outside of the military hospital or clinic, providers should coordinate pre-authorizations and referrals with HNFS based on the specific guidelines established between HNFS and their military hospital or clinic.

Both civilian and military hospital or clinic providers should:

- **Request services** – When services are needed that require a pre-authorization or referral from HNFS, the PCM or referring provider must include a written explanation of the services that are being requested to be performed and sufficient clinical information to assist in the treatment of the beneficiary.
- **Prepare the beneficiary** – The PCM must provide the beneficiary with all the necessary medical records, laboratory results or X-rays, etc., for the beneficiary's appointment.

HNFS will contact the provider's office for further information or clarification, if necessary, to process the pre-authorization or referral request.

If the services meet the required criteria, the beneficiary and the provider will receive a notification letter that lists the specialty provider's name, specialty services, dates, and/or visits that are approved. (Provider notification letters are faxed and posted at **www.tricare-west.com**; beneficiary notification letters are posted online at **www.tricare-west.com**.) The procedure codes listed on HNFS' notification letters are not a guarantee of payment. It is the provider's responsibility to bill the correct procedure code for the actual services rendered.

The beneficiary should use this information to schedule the first appointment with the specialist. Providers are expected to assist their beneficiaries with scheduling the services if assistance is requested.

- For outpatient services, the notification from HNFS will include an authorization number for the approved service(s) or will provide guidance on how to appeal a denied authorization.
- For inpatient services, the notification from HNFS will include a tracking number for the pre-authorization request once HNFS is notified of the admission.

## Prioritizing Pre-Authorization and Referral Requests

To prioritize pre-authorization and referral requests, network providers should follow the guidelines listed in Figure 6.1.

### Prioritizing Pre-Authorization and Referral Requests, Figure 6.1

| | |
|---|---|
| **Routine**<br>When requesting a routine pre-authorization or referral[1] | • Make the request at least seven days prior to the anticipated date of the service.<br>• Submit requests online at **www.tricare-west.com**. |
| **Urgent**<br>When the care is required within 72 hours | • Submit requests online at **www.tricare-west.com** and select "URGENT" when submitting your request and clinical justification.<br>• Do not call HNFS for non-emergent requests unless you do not have the internet or a fax machine. |
| **Emergent**<br>When the care is required within 24 hours | • Submit requests online at **www.tricare-west.com** and select "Emergent" when submitting your request and clinical justification; or<br>• Call HNFS for a telephone referral request at **1-844-866-WEST (1-844-866-9378)**.<br>• Choose the option for authorizations and referrals.<br>• Clearly state the request is emergent when speaking with the HNFS representative. |

## Pre-Authorization and Referral Processing Timelines

HNFS will process requests in the following time frames:

  - Routine requests are processed within two to five business days of receiving the request from the provider.
  - Urgent requests are processed in an expedited manner for care that needs to be delivered within 72 hours.

- Requests are processed using the clinical information submitted by the provider. Processing time for both routine and urgent requests may be delayed if sufficient information is not provided.
- Determination letters for routine and urgent requests are faxed directly to the provider and posted online at **www.tricare-west.com**.
- Beneficiaries can view determination letters for routine requests online at **www.tricare-west.com** within 7 - 10 business days after the request has been processed. Beneficiaries can request email and/or text notifications from HNFS. Determination letters for routine requests will only be mailed on an individual basis upon request.

## Making Changes to Active Authorizations and Referrals

Providers can use the **Outpatient Authorization Change Request Form** to request certain changes to active outpatient authorizations and referrals. The provider submitting this form must be listed as the requesting or servicing provider on the approval notice.

Do use this form to request changes to:

- Servicing provider
- Priority level
- CPT®, HCPCS or diagnosis codes*
- Procedure or service dates

**Some exceptions apply*

Do NOT use this form to request changes:

- If it has been more than 30 days since HNFS approved the services. Submit a new request instead.
- To add services to or extend visits/units on active approved authorizations. Submit a new request instead.
  - ***Tip:*** For services like physical/occupational/speech therapy and allergy visits, you can use a generic request type (for example, P106) and specify codes needed for treatment.
- If the approved services were already rendered.
- To submit new referrals/authorizations
- To submit medical documentation.
- For applied behavior analysis services (ABA) authorized under the Autism Care Demonstration (ACD). Contact our dedicated ACD line for help.
- To submit questions to customer service.

HNFS processes requests within five business days.

**Note:** Do not contact military hospitals or clinics to make changes to an authorization or referral, including changes to the listed provider. Instead, submit requests to HNFS at **www.tricare-west.com**.

## Inpatient Authorization and Referral Changes

If you need to make changes to an existing inpatient authorization or referral (including extensions) you may do so:

- By fax using our **Inpatient TRICARE Service Request Notification** form.

## Appeals of Pre-Authorizations

An appeal is a formal written request by an appropriate appealing party or an appointed representative to resolve a disputed statement of fact.

Under the TRICARE program, the beneficiary has the right to file an appeal (also known as reconsideration) to dispute a denial of pre-authorization for services. Although providers do not normally file appeals for beneficiaries, there are times when a beneficiary may need the provider's assistance with the process.

According to TRICARE guidelines, an appropriate appealing party is:

- A TRICARE beneficiary (including minors)
- A non-network participating provider
- An appointed representative of an appropriate appealing party
- A custodial parent or guardian of a minor beneficiary is considered the "appointed representative" until the beneficiary reaches adult age
- After coming of age, the beneficiary must submit the appeal on his or her own behalf or appoint a representative (for example, parent/guardian) in writing
- Legally appointed representatives
- An attorney, if acting on behalf of an appropriate appealing party

Appeals submitted by anyone other than the above will not be accepted unless he or she has been appointed as a representative by power of attorney or by submitting an **Appointment of Representative for an Appeal** form.

According to TRICARE guidelines, an appropriate appealing party is not:

- A TRICARE network provider. However, the TRICARE network provider may be appointed by an appropriate appealing party to represent him or her in the TRICARE appeal. Refer to the **Appointment of Representative for an Appeal** form.
- A military hospital or clinic provider or other employee of the United States Government. Due to conflict of interest, a military hospital or clinic provider or other federal government employee may not be appointed as a representative (except in the case of a federal government employee or uniformed services member representing an immediate family member).

Denied authorizations which cannot be appealed are:

- Authorizations approved under **point-of-service**
- Authorizations redirected and approved to a network provider when a non-network provider was requested
- Authorizations redirected and approved to a military hospital or clinic
- When the provider is not TRICARE authorized
- Tests denied under TRICARE's Laboratory Developed Test (LDT) Demonstration Project when coverage criteria have not been met
- Denied Supplemental Health Care Plan (SHCP) referrals for ADSMs (ADSMs must follow the waiver process instructions included on the denial letter)

Authorization appeals must be submitted within 90 days of the date on the authorization denial; however, there are additional requirements for expedited appeals as noted below. Appeals can be submitted via fax or email and must include the following:

- Patient's name, address, phone number, and sponsor's SSN or DBN (**Note:** Sponsor DBN is required.)
- Printed name of the person submitting the appeal and the relationship to the patient
- Reason for disputing the denial (required)
- Copy of the initial denial letter and any other documents related to the issue
- Additional documents supporting the appeal

Because a request for reconsideration must be postmarked or received within 90 days from the date of the initial denial determination letter, a request for reconsideration should not be delayed pending the acquisition of any additional documentation. If additional documentation is submitted at a later date, the letter requesting the reconsideration must include a statement that additional documentation will be submitted and the expected submission date of the additional documentation. Upon receipt, a second reviewer who was not involved in the initial denial decision will review the request.

The type of appeal available depends on whether the care has already been received and the urgency of the situation. Instructions for filing the request for reconsideration are provided in the HNFS denial notification letter.

Processing times for appeals are as follow:

**Nonexpedited** – Processed within 60 calendar days (usually within 30 calendar days)

- All authorizations denied as "not a TRICARE benefit" are processed as nonexpedited.
- Authorizations denied as "not medically necessary" that do not meet the requirements of urgent expedited or expedited, are processed as nonexpedited. If the denied services have been performed or supplied, the appeal is processed as nonexpedited.
- Non-network providers cannot request an expedited reconsideration/appeal.

**Expedited** – Processed within three business days

- Expedited appeals are for care that has not been rendered, or if the denial is for continued inpatient stay or the patient has not been discharged.
- The expedited appeal process only applies to care denied as "not medically necessary."
- Services denied as "not a TRICARE benefit" cannot be processed as expedited.
- The expedited appeal must be filed by the beneficiary or appointed representative of the beneficiary.
- Unless they are appointed as a representative by the beneficiary, providers cannot submit an expedited appeal.
- Appeals must be postmarked and received within eight calendar days of the date on the denial letter. If postmarked or received after the eighth day, the appeal will be processed as nonexpedited.

**Urgent expedited** – Processed within 72 hours

- Urgent-expedited appeals are for care that has not been provided.
- The urgent-expedited appeal process only applies to care denied as "not medically necessary." Services denied as "not a TRICARE benefit" cannot be processed as urgent expedited.

The appeal must include a statement from the provider justifying the urgent need, where waiting three business days (expedited processing) could result in:

- Seriously jeopardizing the life or health of the patient or patient's ability to regain maximum function.
- Subjecting the patient to severe pain that could not be adequately managed without the requested care.

An urgent-expedited appeal must be received or postmarked within 90 days of the denial determination letter. The request should state "Urgent-Expedited Reconsideration" and be faxed to the urgent-expedited fax number listed in the denial letter.

**Note:** Denial of continued inpatient stay should be submitted by noon the day after the denial letter has been received.

You may submit your request via:

| | |
|---|---|
| **Fax** | HNFS' confidential fax number at **1-844-769-8007** |
| **Mail** | Health Net Federal Services, LLC<br>TRICARE West Region Authorization Appeals<br>PO Box 2219<br>Virginia Beach, VA 23450-2219 |

## Active Duty Service Member Reconsiderations

Under TPR, if a service member is notified by his or her PCM, TRICARE-authorized provider, a network provider, HNFS, or the SAS that a request for services has been denied, a service member may have the right to reconsideration. ADSMs may direct questions and initiate reconsiderations by calling the Defense Health Agency (DHA)-Great Lakes (DHA-GL) at **1-888-647-6676**. If the provider submits the reconsideration on behalf of the service member, the provider must obtain an **Appointing a Representative for an Appeal** form signed by the service member.

# Providing Care to Beneficiaries From Other Regions and Overseas

## Emergency Care

For emergency care, TRICARE never requires pre-authorizations or referrals, regardless of where beneficiaries receive care. However, to avoid penalties or denial of a claim, providers must notify the appropriate regional contractor: HNFS for the West Region, Humana Military for the TRICARE East Region (East Region), and International SOS for the TRICARE Overseas Program). TRICARE Prime (TRICARE Prime, TPR, TYA Prime) beneficiaries are instructed to contact their PCM within 24 hours of an inpatient admission – or by the next business day – to coordinate ongoing care.

**Note:** If the condition that prompted the emergency care is found to be routine and there is no evidence that the condition ever appeared to be anything other than routine, the care will be covered under the **point-of-service** option for TRICARE Prime beneficiaries. Exceptions are made if the beneficiary was referred to the emergency department by his or her PCM, regional contractor or the MHS Nurse Advice Line.

## Urgent Care

Refer to "***Urgent Care***" in the ***Important Provider Information*** section of this handbook.

**Note:** If you provide emergency or urgent care services to a TRICARE beneficiary from a different region, the beneficiary will be responsible for paying the applicable copayment or cost-share, and you will submit claims to the region in which the beneficiary is enrolled, not the region in which the beneficiary received care. Reference the "***Claims Processing and Billing Information***" section of this handbook for more information.

**Prime Travel Benefit Program**

The Prime Travel Benefit Program assists TRICARE Prime beneficiaries with expenses incurred for medically necessary, non-emergent and pre-approved specialty care more than 100 miles (one way) from their PCM's office. To qualify, there must be supporting clinical documentation confirming specialty care within 100 miles was not available. Visit **www.tricare.mil** for more information.

## Routine Care in Another TRICARE Region

Whenever possible, TRICARE beneficiaries are instructed to receive all routine care from network providers in their designated regions. However, there are times when beneficiaries will receive routine care in another region.

In such cases, the following guidelines apply:

- TRICARE Select beneficiaries will pay applicable copayments/cost-shares, and providers will submit claims to the region where the beneficiary is enrolled, not the region in which care was received.
- TRICARE Prime beneficiaries will receive a referral from their PCMs or regional contractors for out-of-region care and will pay applicable cost-shares. Providers will submit claims to the region where the beneficiary is enrolled, not to the region where care was received. If a TRICARE Prime beneficiary does not receive a referral for out-of-region care, claims will be paid using the **point-of-service** option.

Refer to the *"Claims Processing and Billing Information"* section of this handbook for more information.

If you have questions about processing claims for beneficiaries from other regions, visit **www.tricare-west.com**.

## Caring for TRICARE Overseas Patients in the United States

ADSMs and family members stationed overseas who travel to the United States may find themselves in need of health care services. They also may look to receive routine and specialty care in the United States versus overseas. If they are enrolled in the TRICARE Overseas Program (TOP)-Prime or TOP-Prime Remote, specific pre-authorization, referral and claims processing guidelines apply.

TOP-Prime and TOP-Prime Remote beneficiaries seeking care stateside may require a pre-authorization and/or referral from the TOP contractor, International SOS, for any non-emergency care (urgent care, routine or specialty). Emergency care does not require pre-authorization; however, the beneficiary should contact their PCM as soon as possible to arrange any necessary follow-up care. Failure to obtain a pre-authorization and/or referral when one is required for care may result in the service being paid under TOP **point-of-service**, which involves higher out-of-pocket costs for the beneficiary.

While TOP-Prime/TOP-Prime Remote beneficiaries have been informed to contact International SOS to obtain referrals for care when traveling stateside, providers may contact International SOS at **1-877-451-8659** on their patients' behalf. Claims for all TOP-Prime/TOP-Prime Remote beneficiaries are processed by the Wisconsin Physicians Service (WPS). For more information about TOP please visit **www.tricare-overseas.com**.

# Medical Records Documentation

HNFS may review your medical records on a random basis to evaluate patterns of care and compliance with performance standards. Each provider should have policies and procedures in place to help ensure that the information in each patient's medical record is kept confidential and is appropriately organized. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis and describe the patient's progress and response to medications and services.

- **Patient identification** – Each page of the chart must include a unique identifier, which may include the patient's identification (ID) number, medical record number and first and last name.
- **Individual records** – Each patient must have his or her own record. If information for different family members is kept in the same folder, each patient must have his or her own separate and individual section.
- **Personal data** – Information must include name, address, date of birth, sex, home, work or contact phone number, and emergency contact information. For children, the parent's home or work phone number or any number where parents can be reached is sufficient. For adults, the phone number of a friend or relative, or any number where a contact may be reached and/or a message left is sufficient.
- **Allergies** – Each record must have an allergy notation in a prominent and consistent place. If a patient has no allergies, this must be noted. "NKDA," "NKA" and "O" are all acceptable notations.
- **Chronic/significant problem(s) list** – A separate list of the patient's chronic/significant problem(s) must be maintained. A chronic problem is defined as one that is of long duration, slow progression or shows little change.
- **Chronic/continuing medication list** – These should be listed on a medication sheet and updated as necessary with dosage changes and the date the change(s) was/were made. All medications taken on an ongoing basis – both prescribed and over the counter – must be noted on the medication list.

  The drug, dose, route, duration, and quantity of all prescribed medications must be noted. A separate medication sheet is recommended, but a physician may also choose to write out all current medications at each visit. Ongoing medications that have been discontinued since the last visit should be noted on the medication sheet.
- **Immunization history** – A history of all immunizations must be documented.
- **Chart legibility** – Charts must be legible to someone other than the writer. A record that is deemed illegible by the reviewer should be evaluated by a second person.
- **Informed consent** – Physicians must document their instructions to the patient regarding any suggested invasive procedure, including notes of alternatives to the proposed procedure, any risk involved with the procedure and acknowledgement of the patient's understanding and their agreement to the planned procedure. An invasive procedure is defined as surgical entry into tissues, cavities

or organs, or repair of major traumatic injuries associated with an operating, delivery, emergency room, or outpatient setting, including physician offices.

- **Provider name/signature, each entry** – An individualized, legible identification of the author, including his or her title, must follow each entry into the medical record, whether the entry is handwritten or dictated.
- **Signature on file** – A record of the patient's signature (authorizing the physician to treat the patient) must be kept in the medical record.
- **Growth chart** – The chart is necessary for all patients aged 14 years and younger. Entries must be made starting at the initial visit and at all subsequent well-child visits.
- **Initial relevant history** – There must be evidence that the patient has been questioned on the initial visit regarding serious accidents, past surgeries and illnesses. This may be an initial self-assessment or a History and Physical (H&P) done by the provider.
- **Smoking status** – Smoking history for patients aged 12 years and older should be documented somewhere in the record if the patient has been seen by the physician for a physical assessment three or more times.
- **Alcohol or substance use disorder (SUD)/abuse** – Alcohol use and/or other chemical substance use for patients aged 12 years and older should be documented somewhere in the record if the patient has been seen by the physician for a physical assessment three or more times.
- **Date of each visit** – Each and every entry must be accompanied by a date (month, date and year).
- **Chief complaint** – Each visit to the physician must have a note specifying the reason for the visit.
- **Physical exam relevant to chief complaint** – A note regarding physical findings in the organ system relevant to the chief complaint should be documented. This includes both normal and abnormal findings and appropriate vital signs.
- **Diagnosis/impression for chief complaint** – The diagnosis identified during each visit should be documented.
- **Appropriate use of consultants** – If a patient problem occurs that is outside the physician's scope of practice, there must be a referral to an appropriate specialist. If the physician refers a patient to a specialist unnecessarily, this also should be noted.
- **Treatment/therapy plan is documented** – Based on the chief complaint, physical exam findings and diagnosis, with the treatment plan clearly documented.
- **Studies ordered appropriately** – The studies ordered should be consistent with the treatment plan as related to the working diagnosis at the time of the visit.
- **Results discussed with patient** – When diagnostic studies are ordered, the physician should document that the results have been discussed with the patient and any questions have been addressed. If this information is not found, the physician or office staff should be asked what system they have for conveying lab or test results to the patient (for example, cards mailed out for abnormal results).
- **Unresolved problems for previous visits addressed** – Documentation should reflect that the physician provides continuous evaluation of problems noted in previous visits.
- **Doctor of medicine (MD) review of studies** – There must be evidence that the physician has reviewed the results of diagnostic studies. Methods will vary, but often the physician will initial the lab report or mention it in the progress notes.
- **Results of consultations** – When the patient is referred to another physician for consultation, there must be a copy of the results of the consult report and any associated diagnostic workup in the chart. Primary physician review of the consultation must be documented. Often the physician initials the consult report. If the PCM needed to take action, this should be documented.
- **Date of next visit** – The progress notes for each visit should contain notes as to the specified time frame in which the patient should return (for example, weeks, months or as necessary).
- **Hospital records** – Pertinent inpatient records must be maintained in the office medical records. These records may include, but not be limited to, the following:
  - H&P
  - Surgical procedure reports
  - Emergency room reports and discharge summaries

  **Note:** For pediatric patients seen since birth by the PCM being audited, the labor and delivery records should be in the chart, including the newborn assessment.
- **Preventive health education** – This refers to health teaching provided to the member appropriate for age and lifestyle.
- **Verification of eligibility** – It is highly recommended providers retain photocopies of both sides of Common Access Cards (CACs) and ID cards or a copy of line of duty (LOD) documentation for future reference.
- ***Health Insurance Portability and Accountability Act* (HIPAA) documentation** – Providers are to retain evidence that a Notice of Privacy Practices was presented to any patient and copies of any signed authorization for disclosure or restriction forms.
- Progress notes specific to beneficiaries receiving approved Extended Care Health Option (ECHO) services
- Notes may be requested for review to determine if ECHO services should be allowed, continued or extended.

Mental health records should contain:

- Administrative information related to patient identification
- Date of the therapy session
- Length of the therapy session
- Assessments obtained through examination, testing and observations
- Note of the patient's current clinical status evidenced by the patient's signs and symptoms
- Treatment plan
- Content of the therapy session

- Summary of intervention
- Documentation of care
- Description of the response to treatment, the outcome of the treatment and the response to significant others
- Summary of the patient's degree of progress toward the treatment goals discharge plan

# Utilization Management

Utilization management is a process that manages the beneficiary at the point of care through prospective review, concurrent review, retrospective review, case management, and discharge planning activities.

HNFS will conduct utilization management, case management and clinical quality management activities on care administered outside of the Military Health System.

## Prospective Review

Prospective review is the process of reviewing and assessing health care services before they are rendered. Prospective review procedures allow for:

- Benefit determination
- Evaluation of proposed treatment
- Determination of medical or psychological necessity
- Assessment of level of care required
- Assignments of expected length of stay for care level type and for facilities not reimbursed on a diagnosis-related group (DRG) basis
- Appropriate placement prior to the delivery of care.

Failure to comply with timeline standards for notification and pre-authorization will result in payment reduction.

Non-physician clinical reviewers will perform benefit determination based on TRICARE policy and first-level review using applicable criteria. Cases requiring medical judgment will be submitted to physician consultants and/or medical directors as an integral part of the provision of medical or psychological peer review.

The prospective review program involves review of requested services for:

- Appropriate placement prior to delivery of care (that is, appropriateness of setting)
- Assessment of level of care required
- Assignment of expected length of stay or treatment duration for those types of care and for non-DRG facilities
- Benefit determination
- Determination of medical or psychological necessity
- Evaluation of proposed treatment or services
- Identification of potential quality issues
- Provider and beneficiary eligibility

Additionally, mandatory pre-authorization requirements for selected services will be applied for elective admissions. Use the **Prior Authorization, Referral and Benefit Tool** to determine if a pre-authorization is required.

## Initial Inpatient Clinical Review

HNFS' process for initial inpatient clinical review requires hospital providers to submit clinical information to establish the care's medical necessity for those who are admitted to their facilities and who have not received a precertification for services. This typically includes beneficiaries who have been admitted urgently or for emergencies, or who have not received a pre-authorization for services.
Inpatient care (both medical/surgical and mental health) requires pre-authorization for TRICARE Prime beneficiaries including ADSMs. For TRICARE Select, TRICARE Reserve Select, TRICARE Retired Reserve, and beneficiaries who have other health insurance, only inpatient mental health care services require pre-authorization.

HNFS' care managers will contact your facility and request the initial inpatient clinical review within 24 hours or the next business day following notification of admission. Documents required may include any or all of the following:

- Emergency room documentation
- History and physical
- Physician orders
- Diagnostic lab results
- Diagnostic radiology results
- Operative reports
- Physician progress notes
- Any other documentation that the reviewer considers essential to establish medical necessity

These documents are due to HNFS within 24 hours – or by the next business day – of the request.

Upon review of the requested clinical information and a determination of medical necessity, a letter containing a tracking number (the initial number of days assigned to the case and the next anticipated follow-up review date) will be sent to your facility. If you have any questions regarding this process, contact the care manager assigned to your facility. The care manager's contact information is listed in the letter from HNFS.

## Concurrent Review

Concurrent review is the evaluation of a patient's continued need for treatment and the appropriateness of current and proposed treatment, as well as the setting in which the treatment is being rendered or proposed.

Concurrent review applies to all levels of inpatient care and partial hospitalization programs. If an admission or an extended stay does not meet the required criteria, a request for further review will be sent to the medical director or peer review panel. When prospective review (pre-authorization) is initiated, HNFS will secure the necessary medical information to support the medical, surgical or mental health care services. Medical necessity and appropriateness of setting and treatment review is performed by utilization managment staff with each concurrent review utilizing InterQual® Level of Care Criteria.

An HNFS medical management representative will contact the hospital at the time of admission to obtain initial clinical information and to discuss discharge planning needs.

Subsequent contacts are made to discuss goals for length of stay and/or confirm discharge. By or before the discharge, it is expected hospitals will arrange a specific aftercare appointment that will occur within 7-10 days for patients not discharging to another facility. This information should be included with the final discharge information transmitted to HNFS.

The concurrent review process focuses on early proactive interventions and discharge planning to ensure that the beneficiary receives quality care and timely provision of care in the most appropriate setting. HNFS will identify potential case management candidates with each concurrent review performed.



## Retrospective Review

DHA has designated HNFS as the multifunction Peer Review Organization (PRO) for performance of the following retrospective review activities: medical record review (inpatient and outpatient), DRG/coding validation, focused reviews (inpatient and outpatient), and the TRICARE Quality Monitoring Contract manager (TQMC).

Medical records are reviewed to:

- Assess the accuracy of information provided during the prospective review process.
- Determine the medical or psychological necessity and quality of care provided.
- Validate the review determinations made by the utilization review staff.
- Determine whether the diagnostic and procedural information and/or discharge status of the patient, as reported on the hospital and/or professional provider's claim, matches the attending physician's description of care and services documented in the medical record.

All cases selected for focused retrospective review will undergo the following review activities:

- **Admission review** – The medical record must indicate that the inpatient hospital care was medically or psychologically necessary and provided at the appropriate level of care.
- **Invasive procedure review** – The performance of unnecessary procedures may represent a quality and/or utilization problem. The medical record must support the medical necessity of the procedure performed. Invasive procedures are defined as all surgical and any other procedures that affect DRG assignment.
- **Discharge review** – Records will be reviewed using appropriate criteria (that is, InterQual) to determine potential problems with questionable discharges, as well as other potential quality problems.
- **Home health prospective payment system review** – A monthly retrospective review of medical records and claims will be reviewed in accordance with the **TRICARE Reimbursement Manual (TRM)**, Chapter 12 to evaluate whether services provided were reasonable and necessary, delivered, coded correctly, and appropriately documented.
- **An Important Message from TRICARE** – TRICARE policy requires that every patient admitted to a hospital receive and sign the **An Important Message from TRICARE** document, which details beneficiary rights concerning coverage and payment of hospital stays and post-hospital services. **An Important Message from TRICARE** also discusses the Notice of Non-Coverage typically used by hospitals to inform patients when their health insurance will no longer pay for hospital care. Providers should note, under the rules of the TRICARE Hold Harmless Policy, they cannot bill TRICARE beneficiaries for non-covered services unless the beneficiary agrees in advance and in writing to pay for such services. Therefore, if the beneficiary does not agree to be discharged from the hospital, the provider must have the beneficiary complete a **Request for Non-Covered Services** form. If the beneficiary signs the form within the stated time frames, he or she will be responsible for the charges. Otherwise, the hospital will be responsible for the beneficiary's charges.
- **DRG validation** – Selected records will receive focused and intensified reviews to assure that reimbursed services are supported by documentation in the patient's medical record. This review must determine if the diagnostic and procedural information and discharge status of the patient, as reported by the hospital, match the attending physician's description of care and services documented in the patient's record.
- **Outlier review** – Claims that qualify for additional payment as cost-outliers will be subject to review to ensure costs were medically necessary and appropriate and met all other payment requirements. In addition, claims that qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature or questionable.
- **Procedures and services not covered by the DRG-based payment system** – International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10) and Current Procedural Terminology (CPT®)-4 codes will provide the basis for determining whether diagnostic and procedural information is correct and matches the information contained in the medical record.

## Case Management Program

The case management program coordinates all aspects of medical and mental health treatment by directing at-risk beneficiaries who require extensive, complex and/or costly services to the most appropriate levels of care necessary for effective treatment. By linking many services, including the military hospital and clinic, and TRICARE regional resources, the case manager can coordinate treatment to provide cost-effective quality care.

A nurse, licensed clinical social worker (LCSW) or other health professional acts as a patient advocate, coordinating the beneficiary's health care between the military hospital and clinic, PCM, specialists, and other health care providers to obtain the best outcome for the beneficiary. They provide cost-effective health care, increase beneficiary satisfaction and obtain additional military and community resources based on appropriate needs and availability of the required services. Conditions that may benefit from case management:

- Catastrophic diagnosis (such as head trauma or spinal cord injuries)
- Chronic long-term disease
- Complex health care needs
- Prolonged rehabilitation needs

HNFS offers TRICARE beneficiaries and their families focused assistance with coordinating their care. Case managers may consult with the TRICARE Health Plan (THP), military hospital and clinic points of contact and providers regarding treatment plans. They also identify relevant resources to meet the beneficiary's needs in a quality and cost-effective manner.

If you have a patient who would benefit from case management, log in at **www.tricare-west.com** to use HNFS' case management online nomination tools, or complete the **Medical Management Nomination** form and mail or fax it to HNFS' Case Management Department. A case manager will contact the beneficiary and his or her physician to discuss individual health care needs.

**Online: www.tricare-west.com**

**Mail:**
Health Net Federal Services, LLC
Case Management
PO Box 9528
Virginia Beach, VA 23450-9528

**Fax: 1-888-965-8438**

Visit the **HNFS Case Management** page for more information.

## Warrior Care Support Program

The Warrior Care Support Program (WCS) provides health care coordination and assistance for severely injured or ill warriors once a military hospital or clinic transitions the patient to the civilian health care system. To ensure total health care support, each program participant is assigned a specific health care coordinator who personally guides the patient through the care continuum, ensuring seamless transitions throughout the various stages of health care and military status changes.

This program was designed to make sure that necessary physical and mental health care services are accessible and provided in a timely, coordinated fashion, and to encourage the warrior to focus on his or her recovery and leave the navigation of health care services to the HNFS Care Coordination Team.

The HNFS Care Coordination Team includes professionals with experience in utilization management, transitional care, case management, social services, and mental health care services. Additionally, a team of HNFS physicians works closely with the HNFS care coordinators to provide support and counsel.

Any uniformed services member, including an activated National Guard and Reserve member who is severely injured and meets WCS diagnosis criteria, will be evaluated for entry into WCS.

WCS participants benefit in many ways. The program simplifies the transition process, both within and outside of civilian care settings, assists with benefit coverage and associated changes in military status and streamlines access to a comprehensive HNFS provider network. The HNFS provider network includes specialty services for traumatic brain injuries, post- traumatic stress disorder (PTSD) and other severe conditions.

Uniformed services members are typically enrolled in the program after being identified through referrals from medical management (for example, utilization management, transitional care, case management) or other HNFS associates. Other WCS enrollments may occur through a military hospital or clinic or network provider pre-authorizations or referrals.

If you are caring for an ADSM with significant health care challenges, please call **1-844-866-WEST (9378)** to speak with an HNFS representative about WCS.

## Discharge Planning

The intensity of services reflects when a patient's illness decreases in severity and/or begins to stabilize. If care may be delivered in a less emergency-oriented setting, the medical management staff will coordinate efforts with the physician directing the care (and the patient and family members) to facilitate timely and appropriate discharge. HNFS will initiate discharge planning for all admissions during the first review of the case.

## Transitional Care Program

The Transitional Care Program is designed for all beneficiaries to ensure a coordinated approach takes places across the continuum of care. Transitional care begins in the outpatient setting, progresses through an inpatient stay and provides additional assistance at the time of discharge from acute care to home.

Some examples of services that may be provided by the care manager may include, but not be limited to, pre-admission counseling and prospective discharge planning and education. This program will also fill the gap for the mild to moderately complex beneficiaries who may not qualify for other programs, such as case management or disease management, but still require more intense management of their health care needs.

All records requested by HNFS in support of PRO functions must be submitted to HNFS within 30 calendar days and will be compensated in accordance with the **TRICARE Operations Manual (TOM)**. Any incomplete or unsubmitted records are subject to technical denial for the requested dates of stay, and HNFS may recoup claims payment.

All records requested by HNFS in support of utilization management, case management and clinical quality management (CQM) activities also must be submitted within 30 calendar days but will not be subject to reimbursement compensation.

### Policy on Separation of Medical Decisions and Financial Concerns

HNFS has a strict policy:

- Utilization management decisions are based on medical necessity and medical appropriateness.
- HNFS does not compensate physicians or nurse reviewers for denials.
- HNFS does not offer incentives to encourage coverage or service denial.
- Special concern and attention should be paid to underutilization risk.

Medical decisions regarding the nature and level of care to be provided to a beneficiary, including the decision of who will render the service (for example, PCM versus specialist, network provider versus non-network provider), must be made by qualified medical providers, unhindered by fiscal or administrative concerns. HNFS monitors compliance with this requirement as part of its quality-improvement process.

## Clinical Quality Management

HNFS is committed to providing the highest quality health care possible to TRICARE beneficiaries by partnering with TRICARE providers who share this goal.

In compliance with DOD requirements, HNFS has a CQM program for assessing and monitoring care and services rendered to TRICARE beneficiaries throughout the health care delivery system.

The CQM program was designed to identify and analyze issues and, when needed, to implement timely and appropriate corrective action. Potential quality issues (PQI) are referred to the CQM Department for review. To reduce unfavorable variation and promote favorable outcomes, CQM may request corrective action plans and follow up to:

- Ensure the interventions have been implemented and remain effective.
- Conduct studies and/or quality improvement projects on Healthcare Effectiveness Data and Information Set (HEDIS) measures or U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators.
- Use administrative data monitors to enable a more comprehensive view of PQIs and patient safety issues.
- Expand our provider and beneficiary educational initiatives. The program achieves this by reviewing potential quality issues/patient safety issues, resolving beneficiary and provider grievances and performing clinical quality review studies. Peer review and compliance with professionally recognized standards form the basis of the PQIs/patient safety investigation process. Periodic reassessments assure that improvements remain effective.

Corrective action may include but not be limited to:

- Provider notification (by oral or written contact) and education (for example, through required further training)
- Provider recertification for procedures or services or in-service training for staff
- Submission of a corrective action plan for review and follow-up monitoring
- Administrative policies and procedure revision as appropriate
- Prospective or retrospective trend analysis of practice patterns
- Intensified review of practitioners or facilities, including but not limited to, requirements for second opinions for procedures, retrospective or prospective review of medical records, claims, or requests for pre-authorization
- Modification, suspension, restriction, or termination of participation privileges

## Credentialing

HNFS conducts an initial review on each potential network provider's credentials to determine if the provider meets the minimum criteria. All providers who wish to contract with HNFS are required to complete an application form and participate in an extensive review of qualifications, education, licensure, malpractice coverage, etc. HNFS retains the right to deny or terminate any provider who does not meet or no longer meets HNFS, TRICARE or URAC standards (this includes delegated providers). Not including delegated providers, HNFS conducts a full recredentialing review of health care providers every three years to help maintain current, accurate files and to ensure all providers meet credentialing requirements. HNFS will conduct a credentialing/recredentialing review of a minimum sample size of 15 delegated provider credentialing and recredentialing files annually to fulfill updated URAC requirements. As a TRICARE network provider, you are required to recredential, which includes updating qualifications, education, licensing, malpractice coverage, adverse actions, etc.

There may be times between credentialing cycles when it is appropriate to add, change or delete a specialty description as represented in the provider directory. To make this change, you may need additional education or training documentation if it was not verified or requested during the previous credentialing process. Visit **www.tricare-west.com** for the appropriate forms, information and instructions. Refer to the **Credentialing** page at **www.tricare-west.com** to learn more about HNFS' credentialing process and requirements.

### CAQH

HNFS participates in the **CAQH® Provider Data Portal** (formerly known as CAQH ProView®) initiative (except for providers in Minnesota* or Washington**). CAQH Provider Data Portal is an online tool that streamlines the credentialing process for network providers, allowing them to submit a universal application to CAQH for distribution to authorized health plans (for example, HNFS). The application meets most of the credentialing data requirements of participating health plans

and health care organizations. There is no cost to submit an application and participate with CAQH. Providers are responsible for ensuring their individual CAQH profiles are current and accurate to complete the credentialing process.

*Providers in Minnesota can use **CAQH® Provider Data Portal** or **Minnesota Credentialing Collaborative**.

**Providers in Washington must use **OneHealthPortProviderSource** for credentialing.

## Conditions of Participation for Network Providers

The following summarizes the general conditions required to participate as a TRICARE network provider:

- For providers eligible to participate in Medicare, have a signed **Medicare CMS-460 Agreement** or participate with Medicare on a claim-by-claim basis for eligible Medicare beneficiaries.
- Provide a SSN for all claims processing; an Employer Identification Number (EIN) may be provided, if group only, but additional information will need to be collected for the required individual criminal history background checks.
- Provide a Network Provider Identifier (NPI) for all individuals (Type I) and entities (Type II) billing with your organization.
- Provide a service that is a covered benefit to the plan member.
- Agree to conditions of participation per the network agreement.
- Maintain professional liability coverage in accordance with your network agreement, but generally the limits are at least $200,000 per occurrence and $600,000 aggregate
- All physicians who have active hospital privileges, be in good standing, at The Joint Commission or Healthcare Facilities Accreditation Program (HFAP)-accredited facilities or Det Norske Veritas (DNV)-accredited facilities (may be waived under specific conditions).
- Have a current, valid, unrestricted U.S. Drug Enforcement Administration (DEA) certificate or state-issued controlled substance certificate, if applicable.
- Have completed education and training appropriate to application specialty(ies).
- Sign and include an unmodified *"Credentials Attestation, Authorization and Release."*
- Provide supporting documentation for all confidential questions on the application (no patient names, please).
- Cannot have been separated from the military or from the Veteran's program for clinical performance issues. In addition, cannot have a National Practitioner Data Bank report from a military service related to a clinical quality issue.

Do not have:

- Unexplained gaps in work history for the most recent five years.
- Malpractice history that is excessive for area and specialty.
- Current Medicare or Medicaid sanctions.
- Current disciplinary actions including but not limited to licensure and hospital privileges.

Additional Requirements Exclusively for PCMs

- Provide 24-hour medical coverage.
- Agree to refer TRICARE beneficiaries for specialty care, when necessary.
- Have a valid Tax Identification Number (TIN) for the applicable practice site(s).

## Delegated Credentials/Subcontracted Provider Functions

TRICARE network providers who have delegation agreements with HNFS must comply with agreement standards and functions as they apply to credentialing of network providers and/or other subcontracted functions. Network providers must comply with the following:

- Credentialing plan and policies and procedures meet HNFS' reasonable standards, guidelines and any required national accrediting standards.
- Comply with HNFS' credentialing criteria (credentialing standards).
- Comply with applicable state and federal regulations (including compliance with applicable Centers for Medicare & Medicaid Services [CMS] Medicare laws, regulations and CMS instructions).
- Be properly credentialed and recredentialed before rendering covered services to beneficiaries (includes current and future professional providers).
- Notify HNFS in writing of all new professional providers who become affiliated with and are credentialed by the network provider.
- Cooperate with HNFS' timelines and schedules related to the production of accurate provider directories.
- Maintain all records necessary for HNFS to monitor the effectiveness of network providers' credentialing and recredentialing process, including, but not limited to, records related to the credentialing of all current or future professional providers (professional provider records).
- Annually, or upon reasonable request, provide HNFS with credentialing policies and procedures for review and evaluation, and permit and cooperate with HNFS' review of records.
- Submit credentialing and recredentialing reports that identify those professional providers credentialed/recredentialed, the effective date of such actions, the most recent prior date of credentialing/recredentialing, and the effective date of such professional providers' participation.
- Notify HNFS of any material change in performing delegated functions.
  - Upon written notice, HNFS has the right to revoke and assume the delegated functions and responsibilities if HNFS determines the provider either does not or will not have the capacity, ability or willingness to effectively perform, or is not effectively performing the delegated function.

- Sub-delegation of any delegated functions to another organization requires that the provider request HNFS' prior approval in a written request.
- No sub-delegation may occur prior to HNFS' review and written approval. At HNFS' sole discretion, it may approve or deny any requested sub-delegation. If HNFS approves any sub-delegate, then any sub-delegated function remains subject to the terms of the delegation agreement between the provider and HNFS. HNFS retains ultimate oversight of any functions of the sub-delegate.

HNFS retains the right to:

- Approve new professional providers and sites and to terminate or suspend individual professional provider contracts.
- Approve or deny any provider or site seeking to participate with HNFS.
- Audit performance of delegated functions at any time and at least every three years.
- Perform an annual review of a minimum sample size of 15 credentialing/recredentialing files per updated URAC requirements.
- Audit as frequently as necessary to assess performance and quality.
- Revoke and assume the functions and responsibilities delegated to the provider if the provider fails to comply or correct any delegated functions within a specified period identified by HNFS in a written notice.

# Fraud and Abuse

Health Net Federal Services, LLC (HNFS) has an entire team dedicated to combatting fraud, waste and abuse (FWA) against the TRICARE program. HNFS's Program Integrity Unit employs a team of knowledgeable professionals dedicated to detecting, investigating, preventing, and remedying FWA. The team includes investigators, with over three decades of TRICARE experience, who collaborate with certified medical coding auditors, and clinical nurse reviewers to resolve allegations of FWA. Program Integrity review every allegation of FWA thoroughly, and in matters where there is a clear indication of intent to defraud or if there are serious issues concerning quality of patient care, we will refer to the government for further investigation and possible prosecution.

## Fraud

Fraud is an intentional deception or misrepresentation of fact that can result in unauthorized benefit or payment.

Examples of fraud:

- Submitting claims for services not provided or used
- Falsifying claims or medical records
- Misrepresenting dates, frequency, duration, or description of services rendered
- Billing for services at a higher level than provided or necessary
- Falsifying eligibility
- Failing to disclose coverage under other health insurance (OHI)

## Abuse

Abuse means actions that are improper, inappropriate, outside acceptable standards of professional conduct, or medically unnecessary.

Examples of abuse:

- A pattern of waiving cost-shares or deductibles
- Failure to maintain adequate medical or financial records
- A pattern of claims for services not medically necessary
- Refusal to furnish or allow access to medical records
- Improper billing practices (unbundling, CPT code manipulation, etc.)

Fraudulent actions can result in criminal or civil penalties. Fraudulent or abusive activities may result in administrative sanctions, including suspension or termination as a TRICARE-authorized provider. The DHA Office of the Inspector General works in conjunction with the Program Integrity Department to deal with fraud and abuse.

The DOD Inspector General and other agencies investigate TRICARE fraud.

During an investigation into any allegation of fraud, the Program Integrity Department will determine the following information:

- Whether the fraud occurred.
- When the fraud occurred (time frame).
- Where the fraud occurred.
- Detailed description of the fraudulent activity.

Providers can report an incident one of three ways:

1. Complete the **Program Integrity Fraud, Waste and Abuse Form** and return it to HNFS via email, fax or postal mail:

| | |
|---|---|
| **Phone** | TRICARE Fraud and Abuse Hotline<br>**1-844-886-2206** |
| **Email** | **Program.Integrity@hnfs.com** |
| **Online** | **www.tricare-west.com** |
| **Mail/Fax** | Health Net Federal Services, LLC<br>ATTN: Program Integrity<br>PO Box 10310<br>Virginia Beach, VA 23450-10310<br>**Fax: 1-844-734-1266** |

2. Submit an electronic report at **www.tricare-west.com**.
3. Call HNFS' Fraud Hotline at **1-844-866-2206**.

# Grievances

A grievance is a written complaint or concern about a medical provider, HNFS or the TRICARE program in general. Appeals and claim review issues are separate from grievances.

The HNFS grievance process allows full opportunity for any TRICARE beneficiary, beneficiary's representative, network or non-network civilian or military provider to report in writing any concern or complaint (grievance) regarding health care quality or service. Grievances are generally resolved within 60 days of receipt. Following resolution of a grievance, the grievant/aggrieved party will be notified of the review completion.

## Grievance Issues

Issues may include but not be limited to:

- Quality of health care or service aspects, such as: accessibility, appropriateness, level and continuity of care, timeliness, effectiveness, and outcomes
- Demeanor or behavior of providers and their staff
- For any part of the health care delivery system (including performance of HNFS associates):
  - Poor performance
  - Low/insufficient level of courtesy
  - Lack of professional behavior
- Practices related to patient safety
- Inadequate privacy safeguards
- HIPAA violations
- Delays in processing pre-authorizations and referrals

If multiple patient grievances are received regarding an individual provider, HNFS may limit the provider from receiving future referrals or terminate the provider from the network.

## Required Information for Grievances

Beneficiary-submitted grievances must include:

- Beneficiary's name, address and telephone number (including area code)
- Sponsor's personal identification number (sponsor's SSN or DBN)
- Beneficiary's date of birth
- Beneficiary's signature

A description of the issue or concern must include:

- Date and time of the event
- Name of the provider(s) and/or person(s) involved
- Location of the event (address)
- Nature of the concern or complaint
- Details describing the event or issue
- Appropriate supporting documents

Additional information may be required when submitted by someone other than the involved beneficiary.

The involved beneficiary or representative may submit written grievances by mail or fax; however, if a representative is submitting a grievance, an **Authorization to Disclose Health Information form** must be included.

Submit a **TRICARE West – HNFS Grievance form** or a letter outlining the grievance information previously listed in one of the following ways:

| | |
|---|---|
| **Fax** | **1-844-802-2531** |
| **Mail** | **Health Net Federal Services, LLC**<br>ATTN: Grievances<br>PO Box 8128<br>Virginia Beach, VA 23450-8128 |

## Disputes Related to Network Status

Providers whose network status has been terminated have the right dispute the termination with the following exceptions:

- Terminations due to not meeting conditions of HNFS/TRICARE participation
- Terminations without cause per the provider participation agreement

Dispute submission instructions, including deadlines, are detailed in all network termination letters.

# Claims Processing and Billing Information

## TRICARE West Region Claims Processor

PGBA, LLC (PGBA) is Health Net Federal Services' (HNFS) partner for claims processing in the TRICARE West Region (West Region). The HNFS website, **www.tricare-west.com**, offers many online claims customer service features, including eligibility, claim status and electronic claims submission.

Wisconsin Physicians Service (WPS) – Military and Veterans Health is the claims processor for all TRICARE For Life (TFL) claims. Claims for certain home infused or injected medications will be processed by Express Scripts, Inc. but first must be coordinated through HNFS.

TRICARE network providers must file TRICARE claims electronically with HNFS/PGBA, even when a patient has other health insurance (OHI).

**Note:** Except for applied behavior analysis providers, network providers in the state of Alaska are not required to submit claims electronically.

Non-network providers are encouraged to take advantage of the electronic claims and electronic funds transfer (EFT) features available through HNFS and PGBA. To learn more about submitting claims, visit **www.tricare-west.com**.

## Claims Processing Standards and Guidelines

The following information provides guidelines for processing claims in the West Region.

TRICARE network providers must file all claims electronically (refer to ***Electronic Claims Submission*** later in this section). HNFS strongly recommends filing claims within 90 days of the date of service. Claims must be submitted no later than one year from the date of service or discharge in accordance with TRICARE policy.

**Note:** Except for applied behavior analysis providers, network providers in the state of Alaska are not required to submit claims electronically.

When TRICARE is the secondary payer, the submittal time frame will commence once the primary payer has made payment or denied the claim. HNFS offers payments and remittances by National Provider Identifier (NPI) number. The NPI billed on the claim will determine where payment and remittance will be sent.

### HIPAA National Provider Identifier Compliance

TRICARE requires electronic claims be filed using the appropriate Health Insurance Portability and Accountability Act (HIPAA)-compliant and standard electronic claims format. If a non-network provider must submit paper claims, TRICARE requires use of either a 1500 (professional charges) or a UB-04 (institutional charges) claim form.

All covered entities must use their NPIs on HIPAA standard electronic transactions in accordance with the *HIPAA Transaction Electronic Data Interchange for Health Care Providers Implementation Guide*. When filing claims with NPIs, billing NPIs are always required. When applicable, rendering provider NPIs are also required. Providers treating TRICARE beneficiaries referred by another provider should also obtain the referring provider's NPI and include it on transactions, if available. Refer to the ***Important Provider Information*** section of this handbook for additional details on HIPAA NPI compliance.

## Important Billing Tips

There are several reasons why claims are delayed or denied unnecessarily. The following are some helpful billing tips to help facilitate prompt claim payments. Many of these tips are based on paper claims submissions; however, you can find specific electronic claims and billing tips for various covered services at **www.tricare-west.com**.

- **Active duty service member (ADSM) claims** – Send TRICARE Prime Remote (TPR) and Supplemental Health Care Program (SHCP) claims to PGBA for processing and payment. There are no copayments, cost-shares or deductibles for ADSMs.

  **Note:** ADSM claims will be paid at the same negotiated rate as stated in the provider agreement.

  The same balance billing limitations applicable to TRICARE apply to the SHCP. For more information regarding balance billing, reference the "***Important Provider Information***" section of this handbook.

- **Additional pre-authorization** – If you render additional services beyond what has been covered by the initial pre-authorization, you must notify HNFS to request an authorization extension to ensure correct claims payment.
- **Admitting diagnosis** – The admitting diagnosis is required on all UB-04 inpatient claims.
- **Anesthesia claims** – Claim submissions must include the five-digit Current Procedural Terminology (CPT®)-4 anesthesia code, start and stop times and the appropriate anesthesia modifier. Claims submitted with surgical codes will be denied.
- **Beneficiary signature** – Include the TRICARE beneficiary's signature in Boxes 12 and 13 of the 1500 claim form. You may indicate "patient not present" if the beneficiary's signature is on file. For laboratory and X-ray services, you may indicate "patient does not present for services." Also include the TRICARE sponsor's Department of Defense (DOD) Benefits Number (DBN) or Social Security number (SSN) in Box 1a of the 1500 claim form or FL 60 of the UB-04 claim form.
- **Breast pump supply claims** – Include appropriate **breast pump supply modifiers** when billing Healthcare Common Procedure Coding System (HCPCS) codes A9900 or A9999. These modifiers let HNFS know specifically which supplies are being provided to the beneficiary.

  **Exception:** When billing for breast milk storage bags, use K1005 with no modifier.
- **Claims status** – Check claim status online at **www.tricare-west.com** or by calling **1-844-866-WEST (1-844-866-9378)** and accessing the automated phone menu options.
- **Claims questions** – Submit secure electronic mail questions regarding your claims using *Ask Us* (login required) at **www.tricare-west.com**.
- **Clean claims** – Most clean claims (claims that are complete and comply with all billing guidelines and requirements, including substantiating documentation) will be processed within 30 days. Generally, claims aged more than 30 days will be paid interest in addition to the payable amount. Claims requiring special processing may prevent timely payment.
- **Corrected claims** – If you submitted the original claim via electronic data interchange (EDI), you also can submit the corrected claim via EDI. If you submit paper claims, you can use **XPressClaim** to submit corrected claims. If you have more than one claim to correct, submit each corrected claim on a separate claim form (do not put additional claim numbers in the notes section to combine corrections for multiple claims).

  **Note:** If your claim was completely rejected or denied, submit a new claim rather than a correction.
- **Demographic changes** – You must inform HNFS if any changes occur in professional affiliation, Tax Identification Number (TIN), office location, telephone number, and general or pre-authorization/referral fax number. Refer to "***Updating Provider Information***" in **Section 2** of this handbook.
- **Dual-eligible beneficiaries for Medicare and TFL** – Submit claims for dual-eligible beneficiaries to Medicare first. Claims automatically transmit from Medicare to TRICARE for secondary claims processing, and WPS will process the TRICARE portion of the claim. Refer to ***Claims for Beneficiaries Using Medicare and TRICARE For Life*** later in this section for more information.
- **EDI** – Contact your clearinghouse or vendor to make sure they are using the correct payer identification (ID). They may have a proprietary ID for you to use prior to submitting claims to PGBA – HNFS' partner for claims processing. The West Region Payer ID is 99726.
  **Note:** If your clearinghouse is Change Healthcare, the West Region payer ID is SCWI0 for professional claims and 12C01 for institutional claims.
- **Hospital** – Bill all appropriate revenue and CPT codes on a UB-04 institutional claim form.
- ***International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-*5*) Codes** – When billing ICD-10 diagnosis codes, crosswalk code services to the highest level of specificity (that is, seven-digit level). DSM-5 codes are required for mental health conditions.
- **Injectables** – For injectables administered in the office, bill the appropriate HCPCS code for the injectable being administered. When billing for a drug for which there is no defined allowable in the Medicare "J" Code Pricing File, provide the appropriate HCPCS code and the applicable National Drug Code (NDC) printed on the manufacturer's drug packaging label in Column 24D of the 1500 claim form. Ensure that the appropriate units are indicated in Column 24G of the 1500 claim form.
- **Itemization/breakdown of charges** – Be sure to complete Section 24, Columns A–J (for example, date[s] of service in Column A, place of service in Column B, charges in Column F) of the 1500 claim form to ensure charges are itemized correctly.
- **Laser surgery** – Submit claims for laser surgery with a laser-specific CPT code for appropriate reimbursement. Without the laser surgery code, the claim will be reimbursed as a conventional surgical procedure.
- **Maternity antepartum care** – Submit claims with the appropriate level of service codes. Refer to the current edition of the CPT publication.
- **Medicaid third party liability and coordination of benefits** – PGBA's proprietary electronic claims system for filing secondary claims with Medicaid can assist in facilitating the flow of claims between TRICARE and Medicaid and significantly reduce the amount of paperwork required when large batches are submitted. Contact the EDI help desk at **1-800-259-0264** for more information.
- **Modifiers and condition codes** – Industry standard modifiers and condition codes may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply when billing.

- **National Provider Identifier (NPI)** – Include all applicable NPIs. TRICARE providers should already have NPIs. If you do not have an NPI, complete the online **National Plan & Provider Enumeration System** application or download a paper application. If you bill with a Type 2 NPI for both professional and facility services, you must notify HNFS so we can properly identify the Type 2 NPI in our systems. Providers with Type 2 NPIs who are not identified as professional entities (for example, physician groups) cannot be reimbursed for submitted professional services. Similarly, providers with Type 2 NPIs who are not identified as institutional entities (for example, hospitals) cannot be reimbursed for submitted professional charges.
- **OHI** – Always ask the patient if he or she has OHI. It is your responsibility to submit OHI benefit information in Boxes 4, 9 (a–d), 11d and 29 on the 1500 claim form or FL 34, 50, 54 and 58 of the UB-04 claim form or submit an explanation of benefits (EOB) statement from the OHI carrier along with the TRICARE claim if submitting a paper claim. For EDI billing instructions, visit **www.tricare-west.com**.

  **Note:** You may not bill the beneficiary for cost-shares or copayments when the OHI has paid more than the contractual TRICARE-allowable charge.
- **Out-of-region claims** – Submit claims to the TRICARE region where the beneficiary resides and/or is enrolled. Refer to "***Processing Claims for Out-of-Region Care***" later in this section.
- **Outpatient hospital clinic billing** – When billing for provider outpatient services in a hospital setting, certain guidelines must be followed. This allows the claim to process in a timely manner and prevents the TRICARE beneficiary from being charged a double copayment.
- **Patient identification number** – Military ID cards contain two numbers assigned by the DOD: the DBN is an 11-digit number found on the back of the card and the DOD ID number, which is a 10-digit number located on the front of the card. Only the 11-digit DBN can be used as the patient ID number on TRICARE claims.
- **Physician assistants/nurse practitioners** – When billing for a physician assistant or any other rendering provider (other than the individual provider shown in Box 33 of the claim form), you must include the rendering provider's NPI in Box 24J and the provider's NPI in block 32/33 of the 1500 claim form.
- **Place of service codes** – Use the correct place of service codes (see Box 24B of the 1500 claim form).
- **Pre-authorization** – Certain services require a pre-authorization from HNFS.

  **Note:** Per the **TRICARE Reimbursement Manual (TRM)**, Chapter 1, network and non-network provider claims submitted for services rendered without a required pre-authorization are subject to a 10% penalty of the negotiated rate. For a network provider, the penalty may be greater than 10% depending on whether his or her network contract includes a higher penalty. These payment reduction penalties cannot be passed onto the beneficiary for payment. It is the provider's responsibility to obtain pre-authorization when required.
- **Provider:** Bill place of service (POS) 19 or 22 on a 1500 claim form. Do not use POS 11 or the beneficiary will receive a separate copayment from the hospital.
- **Provider signature** – Always include the provider's signature or use a signature stamp in Box 31 of the 1500 claim form. The signature stamp must be on file with HNFS/PGBA. "Signature on File" is an acceptable signature on electronic claims only. Because the provider's signature block FL was eliminated from the UB-04 institutional claim, the National Uniform Billing Committee has designated FL 80 (Remarks) as the location for the provider signature if signature-on-file requirements do not apply to the claim.
  **Note:** All non-network claims must have a provider's signature or an acceptable facsimile, in accordance with the **TRICARE Operations Manual (TOM)**, Chapter 8. If a non-network claim does not contain an acceptable signature, the claim will be returned.
- **Service location address** – Much of TRICARE pricing is based on geographic locality; therefore, it is important to include the physical service location address for any services not rendered at the billing provider's physical location.
- **Services provided on behalf of another provider** – Always clearly indicate "On Call" in a prominent place on the 1500 claim form for services performed on behalf of another provider. If submitting paper claims, do not use red ink stamps.
- **Services that require specific units of service** – When billing for these services, such as allergy testing and treatment, be sure to code units of service based on the description in the most current edition of the **CPT publication**.
- **Supporting documentation** – To expedite claims processing, use the Upload Documents tool when logged in at **www.tricare-west.com** to submit supporting documentation, rather than sending via U.S. postal mail.
- **Tax Identification Number (TIN) and address** – All claims must include the provider's federal TIN in Box 25 of the 1500 claim form, the service facility location information (including ZIP code) in Box 32 and the billing provider's pay-to address, ZIP code and phone number in Box 33. On the UB-04 institutional claim form, enter the physical address of the facility where the care was provided in the Form Locator (FL) 1 field and enter the pay-to address in the FL 2 field. The facility's federal TIN is entered in the FL 5 field.
- **Third party liability (TPL)** – If billing for care that may involve TPL (ICD-10 diagnosis S and T codes ending with the seventh character of A), instruct the beneficiary to promptly respond to any request for TPL information. Once the beneficiary returns the signed TPL form (**DD Form 2527 Statement of Personal Injury—Possible Third Party Liability**) to HNFS, the claim will be processed.
- **TRICARE summary payment voucher/remit** – You will receive a copy of the TRICARE Summary of Payment Voucher/Remit with your payment from HNFS. The TRICARE Summary of Payment Voucher/Remit will reflect the services provided that pertain to the payment. You can also view online remits through **www.tricare-west.com**.

- **Unlisted or unspecific CPT codes** – When submitting a paper claim and billing with an unlisted or unspecified CPT procedure code, you must include supporting documentation describing the services rendered, or the claim will be returned for this information. For electronic claims, include the codes; PGBA will request additional information from you when applicable.
- **XPressClaim** – XPressClaim is a fast, easy and free real-time, online claims processing system available through www.tricare-west.com. Refer to "*Electronic Claims Submission*" later in this section for more information.

## Mental Health Care Claim Tips

- Only physicians and other licensed or certified mental health care providers may bill for psychiatric CPT codes DSM-5 diagnosis range for ICD-10 – F01.50 or F99.
- File hospital and other institutional care claims on UB-04 forms.
- File professional services claims on 1500 claim forms.
- Professional providers should use CPT procedure codes and DSM-5 diagnosis codes to bill for services.
- Facilities should use revenue and HCPCS codes (if required) to bill for services.
- Properly inform beneficiaries in advance if services are not covered. You are financially responsible for any non-covered services you provide to a TRICARE beneficiary who was not properly informed in advance of non-coverage and/or who did not agree in advance and in writing to pay for the non-covered services. Refer to "*Informing Beneficiaries About Non-Covered Services and TRICARE's Hold Harmless Policy*" in the *Important Provider Information* section of this handbook for more information.
- Check claims status online at www.tricare-west.com or through the automated phone menu options at **1-844-866-WEST (1-844-866-9378)**. Claim check services are available 24/7.
- If HNFS denies a claim because you did not obtain required authorization, follow instructions on the remittance statement for assistance.

For more information about partial hospitalization programs (PHP), refer to the TRM, Chapter 7. To learn more about Outpatient Prospective Payment System (OPPS), refer to the "*TRICARE Reimbursement Methodologies*" section of this handbook or TRM, Chapter 13.

## HIPAA Transaction Standards and Code Sets for Mental Health Claims

All health care providers, plans and clearinghouses are required to comply and must use the following standard formats for TRICARE mental health care claims:

- **ASC X12N 837 – Health Care Claim:** Professional, Version 5010 and Addenda
- **ASC X12N 837 – Health Care Claim:** Institutional, Version 5010 and Addenda

TRICARE contractors (HNFS and PGBA) and other health care payers are prohibited from accepting or issuing transactions that do not meet these standards.

For more information on HIPAA transaction standards and code sets, refer to the "*Important Provider Information*" section of this handbook.

## Proper Billing for Multiple Procedures

Do not use the same CPT code billed on multiple lines for the same date of service instead of one line with multiple units. If there are multiple dates of service, each line should be billed separately.

The following are examples for billing a pathology exam on three breast biopsy specimens on the same date of service:

- **Correct way:** One line with the CPT code and three units
- **Wrong way:** Three lines with the CPT code with one unit each

If the claim includes three lines with one unit for each line on the same date of service, the additional lines appear as duplicates, causing the additional lines to deny.

## Medically Unlikely Edit

TRICARE has adopted the Centers for Medicare & Medicaid Services' (CMS) maximum number of services limitations. CMS defines a Medically Unlikely Edit (MUE) as "… the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service." TRICARE's maximum number of services per day that may be billed for specific CPT codes can be found at www.health.mil/rates. If the number of procedures performed in a day exceeds the MUE, medical documentation will be required to prove the procedures were medically necessary.

## Duplicate Claims

Duplicate claims occur when providers resubmit claims that have already been processed through to completion, which may include payment. Other possibilities include claims being processed for partial payment or even denied.

To avoid submitting duplicate claims, providers should reconcile their financial records as soon as possible to avoid the impression of an unpaid balance.

Duplicate claims add unnecessary processing costs that must be paid by the government, as well as additional administrative costs to your practice. Keeping unnecessary health care costs low is the responsibility of all members of the health care community.

Through www.tricare-west.com you can:

- Check TRICARE claims statuses online to verify completed, in process/pending, returned, or transferred claims.
- Reconcile your accounts receivable by viewing TRICARE remits online.

- Sign up for EFT to receive TRICARE payments faster.
- Ensure provider demographic information on file is current and accurate.
- **Note:** Wait at least 30 days before claims resubmission or telephone inquiry. Check the status of a claim at **www.tricare-west.com** or by using the self-service options at **1-844-866-WEST (1-844-866-9378)**.

If after reconciling your accounts you determine payment was not received or you disagree with the payment amount, do not resubmit the same claim. Instead, explain your circumstance or disagreement by requesting a claim review and faxing written correspondence to **1-844-869-2812**.

# Electronic Claims Submission

Electronic claims submission allows you to submit claims directly to HNFS/PGBA, ensuring faster processing and reduced paperwork. Network providers are required to submit all claims electronically.

**Note:** Except for applied behavior analysis providers, network providers in the state of Alaska are not required to submit claims electronically.

Non-network providers are strongly encouraged to submit claims electronically.

The following are options for electronic claims submission:

- **XPressClaim** – A secure, full-service online electronic claims system recommended for providers with internet access who submit fewer than 150 TRICARE claims per month. This service is free, requires no additional hardware or software, accepts 1500 claim forms and UB-04 claims, will adjudicate most TRICARE claims upon submission and provides a clear explanation of what TRICARE allows and what the patient owes.

  Refer to "**XPressClaim**" in this section for more details.
- **Claims clearinghouses** – You can establish clearinghouse services to transmit TRICARE claims electronically to HNFS/PGBA for processing. This option allows you to submit claims to other health care payers as well. Please contact your clearinghouse or vendor to ensure the correct payer identification (ID) is used. The West Region Payer ID is 99726. If your clearinghouse is Change Healthcare, the West Region payer ID is SCWI0 for professional claims and 12C01 for institutional claims. Refer to the **Claims Submission** page at **www.tricare-west.com** for more information.

For assistance, visit **www.tricare-west.com** or call **1-800-259-0264**.

## XPressClaim

**XPressClaim** offers a secure internet-based, real-time, online claims processing system to transmit TRICARE claims 24/7. XPressClaim uses a sophisticated encryption technology to transmit claims securely. The system fully protects the confidentiality of patient records and complies with HIPAA rules and regulations.

You and other office staff can register instantly for XPressClaim at **www.tricare-west.com**.

After registration, XPressClaim will preload patient information for your TRICARE patients from claims that have been processed within the past 12 months. To enter a new patient's information, you need the sponsor's SSN and the patient's date of birth. Providers also can check a patient's claim status, eligibility and OHI information at **www.tricare-west.com**.

XPressClaim can also handle claims submission for groups with multiple locations and multiple providers. To file claims, you will need the following:

- Dates of service
- ICD-10 diagnosis and CPT codes
- Basic data related to the diagnosis

**Note:** You can submit up to 49 lines of information on one XPressClaim submission. Immediately after claim submission, you will receive an online message showing the claim has been accepted for processing. The system also shows the TRICARE-allowable charge and the patient's payment responsibility (if any). You generally can expect PGBA to mail payment within three to five days. If a claim is more complicated and needs to be resolved by PGBA, dedicated associates will process the claim as a priority. In most cases, these claims will be completed within 10 days or less.



# Electronic Funds Transfer

You can sign up for EFT at **www.tricare-west.com**. You must have signature authority to disburse funds; sign checks; and add, modify or remove bank account information.

# Claims Submission Addresses

Figure 7.1 provides a list of addresses related to paper claim submissions for individual, institutional, ancillary, and mental health care providers.

### West Region Submission Addresses Figure 7.1

| | |
|---|---|
| **Claims Submmission** | **Health Net Federal Services, LLC**<br>c/o PGBA, LLC/TRICARE<br>PO Box 202112<br>Florence, SC 29502-2112 |
| **Claims Correspondence** | **Health Net Federal Services, LLC**<br>c/o PGBA, LLC/TRICARE<br>PO Box 202100<br>Florence, SC 29502-2100<br>**Fax: 1-844-869-2812** |
| **Claims Appeals for Non-Network and Network** | **Health Net Federal Services, LLC**<br>Administrative Reviews<br>PO Box 8008<br>Virginia Beach, VA 23450-8008 |

# Hospital and Facility Billing

- Emergency room charges in conjunction with a diagnosis-related group (DRG) reimbursed hospital stay must be billed on a separate outpatient UB-04. Additionally, ambulatory surgery room charges cannot be submitted on an inpatient claim and should be billed as a separate outpatient service on the UB-04 (revenue code 049X).
- Interim claims for DRG-based facilities (regardless of the type of contract with HNFS) are accepted when the patient has been in the hospital at least 60 days. If you submit multiple claims on one patient's behalf, you must submit them in chronological order. Fixed-dollar parameters do not apply.
- Hospital-based outpatient surgical procedures are reimbursed under the TRICARE Outpatient Prospective Payment System (OPPS). Some hospitals are exempt from OPPS. This is mandatory for both network and non-network providers. TRICARE's OPPS closely mirrors Medicare's OPPS method; however, the TRICARE program determines benefits and coverage for the entire military population, regardless of age. For a list of exempt facilities and procedure code changes for TRICARE's **No Government Pay List** and more information regarding TRICARE OPPS implementation, refer to the **TRM**, Chapter 13. TRICARE-OPPS exempt facilities reimburse rates established by TRICARE for outpatient surgical procedures.

  To ensure proper payment for procedures listed in the **TRICARE Ambulatory Surgery Center (ASC) rates**, make sure that ICD-10 surgical procedure codes have a corresponding CPT code and a charge for each CPT code billed.
- Certain surgical procedures normally reimbursed at a hospital-based surgery center also can be reimbursed at a freestanding ASC. TRICARE network providers must contact HNFS to obtain pre-authorization for appropriate procedures performed at an ASC. Refer to **TRICARE Policy Manual (TPM)**, Chapter 11 for more information.
- When billing for provider outpatient services in a hospital setting, the following guidelines must be followed. This allows the claim to process in a timely manner and keeps the TRICARE beneficiary from being charged a double copay.
  - **Hospital:** Bill all appropriate revenue and CPT codes on a UB-04 institutional claim form.
  - **Provider:** Bill Place of Service (POS) 19 or 22 on a 1500 claim form. Do not use POS 11, or the beneficiary will receive a separate copay from the hospital.
- TRICARE-authorized hospital providers must inform HNFS immediately of any change in CMS hospital classification. Notification by the hospital must occur if the provider changes from a short-term acute care hospital classification, critical access hospital classification or sole community hospital classification to any other of the three noted classifications.

This notification allows HNFS to properly reimburse hospitals for TRICARE-covered services.

When notifying HNFS, providers should include the official letter from CMS, the hospital's point-of-contact information and the effective date of the CMS hospital classification change. Providers may fax this required information to HNFS at **1-844-836-5818**.

# Proper Treatment and Observation Room Billing

## Revenue Code 076X

Determining when to use revenue code 076X (treatment) to indicate use of a treatment room can be complicated and improper coding can lead to inappropriate billing.

Under OPPS, 076X revenue codes are reimbursed based on the HCPCS codes submitted on the claim.

You may indicate revenue code 076X for the actual use of a treatment room in which a specific procedure has been performed or a treatment rendered. Revenue code 076X may be appropriate for charges for minor procedures and in the following instances:

- Outpatient surgery procedure code
- Interventional radiology services related to imaging, supervision, interpretation, and the related injection or introduction procedure
- Debridement performed in an outpatient hospital department

Revenue code 0762 (observation room) is the only revenue code that should be used for observation billing. Non-OPPS outpatient observation stays may be reimbursed for a maximum of 48 hours.

# Telemedicine Billing

## Synchronous Telemedicine Services

Synchronous telemedicine services involve an interactive, electronic information exchange in at least two directions during the same time period.

Providers must bill using CPT or HCPCS codes with a GT or 95 modifier for distant site and Q3014 for an applicable originating site to distinguish telemedicine services. By billing the GT or 95 modifier with a covered telemedicine procedure code, the distant site provider certifies the beneficiary was present at an eligible originating site when the telemedicine service was furnished. Payment for Q3014 will not be made when a patient's home is the originating site. The distant site and originating site cannot be billed by the same provider.

For professional claims, use the place of service code that represents the location from which he/she rendered the telemedicine visit. (For example, POS 11 if services are rendered from the provider's office.)

By billing the GT or 95 modifier with a covered telemedicine procedure code, the distant site provider certifies the beneficiary was present at an eligible originating site when the telemedicine service was furnished.

Providers must document the provider and patient location (city/town, state, ZIP code) in the medical record.

### Asynchronous Telemedicine Services

Asynchronous telemedicine services involve storing, forwarding and transmitting medical information from telemedicine encounters in one direction at a time.

Providers must bill using CPT or HCPCS codes with a GQ modifier. For professional claims, use the POS code that represents the location from which he/she rendered the telemedicine visit. (For example, POS 11 if services are rendered from the provider's office.)

**Note**: When submitting claims for telemedicine services, the originating site provider may indicate "Signature not required – distance telemedicine site" in the required Patient Signature field.

### Telephonic (Audio-Only) Office Visits

Current coding manuals include CPT codes 99441–43, 98966–68 and HCPCS code G2012 as audio-only telehealth. CMS 1500 professional claims should have the POS 02 or one of the telemedicine modifiers GT or 95, with appropriate CPT or HCPCS codes. UB04 claims must contain one of the telemedicine GT or 95 modifiers.

## Z Codes

A Z code may designate a primary diagnosis for an outpatient claim that explains the reason for a patient's visit to your office. Z codes should be used for preventive or other screening claims; all other claims should be billed with the standard numeric ICD-10 diagnosis codes.

**Note:** Z-code diagnoses for TRICARE mental health care services are not covered. TRICARE policy defines Z-code diagnoses as "conditions not attributable to a mental disorder."

### How to Bill With Z Codes

Be sure to use the correct Z-code diagnosis to indicate the reason for the patient's visit. The Z code must match the CPT code to indicate a given procedure's correlation to the Z-code diagnosis. Z codes correspond to descriptive, generic, preventive, ancillary, or required medical services and should be billed accordingly. This section covers different types of Z codes and their uses.

### Descriptive Z Codes

For Z codes that provide descriptive information as the reason for the patient visit, you may designate that description as the primary diagnosis. An example of a descriptive Z code is a routine infant or well-child visit, which is designated as Z00.129.

### Generic Z Codes

For lab, radiology, pre-op, or similar services, do not use a generic Z code as a primary diagnosis. Rather, the underlying medical condition should be listed as the primary diagnosis for these ancillary services.

### Preventive Z Codes

For preventive services, a Z code that describes a personal or family history of a medical condition is sufficient as a primary diagnosis without the need for additional diagnostic information. Examples are mammography, a Pap test or a fecal occult blood screening.

Figure 7.2 lists preventive services and the corresponding Z codes.

### Preventive Care Services Z Codes Figure 7.2

| Preventive Care Service | Proper Z Codes Refer to "Covered Clinical Preventive Services" in Section 4 of this handbook for more information. |
|---|---|
| **Colonoscopy** | Z12.11 Encounter for screening for malignant neoplasm of colon<br>Z80.0 Family history of malignant neoplasm of digestive organs<br>Z86.010 Personal history of colonic polyps |
| **Mammograms** | Z12.31 Encounter screen mammogram for malignant neoplasm of breast<br>Z85.3 Personal history of malignant neoplasm of breast |
| **Optometry**<br>(eye exams) | Z01.00 Encounter for exam of eyes and vision w/o abnormal findings<br>Z01.01 Encounter for exam of eyes and vision w abnormal findings<br>Well-Child Benefit:<br>Z00.121 Encounter for routine child health exam with abnormal findings<br>Z00.129 Encounter for routine child health exam w/o abnormal findings |
| **Pap Test** | Z01.411 Encounter for gynecological exam, general, routine, with abnormal findings<br>Z01.419 Encounter for gynecological exam, general, routine, w/o abnormal findings<br>Z01.42 Encounter for cervical smear to confirm normal smear following initial abnormal smear<br>Z12.4 Encounter for screening for malignant neoplasm of the cervix |
| **Sigmoidoscopy** | Z12.12 Encounter for screening for malignant neoplasm of rectum<br>Z12.11 Encounter for screening for malignant neoplasm of colon Z80.0 Family history of malignant neoplasm of digestive organs<br>Z86.010 Personal history of colonic polyps |
| **Regular Immunizations** | Z00.121 Encounter for routine child health exam with abnormal findings<br>Z00.129 Encounter for routine child health exam w/o abnormal findings |
| **School Physical*** (ages 5–11)<br>**Note:** Sports-related physical exams are not a covered benefit. | Z02.0 Encounter for exam for admission to educational institution |
| **Well-Child Visits** (birth through age five years) | Z00.121 Encounter for routine child health exam with abnormal findings<br>Z00.129 Encounter for routine child health exam w/o abnormal findings |

# Allergy Testing and Treatment Claims

TRICARE does not cover certain types of allergy tests. Prior to performing an allergy test, visit **www.tricare-west.com** to verify if the test is an approved benefit.

When submitting claims for allergy testing and treatment, use the appropriate CPT code and indicate on the claim form the type and number of allergy tests performed.

When filing claims for the administration of multiple allergy tests, group the total number of tests according to the most current CPT code book definitions of relevant codes. Under Column 24G of the 1500 claim form, indicate the number of replacement antigen sets (not vials) being billed.

Pending medical review and approval, a limited number of replacement antigen sets are payable. Bill with the appropriate CPT code per replacement antigen set quantity (for example: one vial, two or more vials).

# Eye Exam Claims

For TRICARE Prime (TRICARE Prime, TPR, TYA Prime) beneficiaries, TRICARE covers the following routine eye examinations as clinical preventive services:

- Pediatric vision screening at birth and approximately six months of age to include determination of vision on visual acuity, ocular alignment and red reflex, along with external examination of ocular abnormalities (considered part of a well-child office visit performed by a primary care provider).
- Routine eye examination annually (once every 12 months) for an active duty family member (ADFM).
- Routine eye examination once every 24 months for retirees and eligible family members ages three and older.
- TRICARE covers routine eye exams for TRICARE Prime beneficiaries with diabetes. Routine exams must be billed differently from a diagnostic eye exam to ensure claims are processed accurately.

For TRICARE Select, TYA Select, TRICARE Reserve Select (TRS), and TRICARE Retired Reserve (TRR) beneficiaries, TRICARE covers the following routine eye examinations as clinical preventive services:

- Pediatric vision screening at birth and approximately six months by primary care provider during routine examination (considered a part of a newborn examination or a well-child office visit).
- One routine eye exam annually (once every 12 months) for an ADFM.
- One routine eye exam every 24-month period for beneficiaries ages three through five.
- Routine eye exams are not covered for beneficiaries ages six and older.

For complete eye exam benefit details, refer to "Eye Examinations" in the ***Medical Coverage*** section of this handbook or visit **www.tricare-west.com**.

## Routine Exams

A routine eye exam may include but not be limited to: refractive services, ocular alignment and red reflux and dilation and external examination for ocular abnormalities. The covered CPT codes are:

92002 – Intermediate eye exam, new patient

92004 – Comprehensive eye exam, new patient

92012 – Intermediate eye exam, established patient

92014 – Comprehensive eye exam, established patient

92015 – Refraction

**For all beneficiaries:**
The primary diagnosis on the claim should be routine vision screening. For diabetic beneficiaries, the primary diagnosis on the claim also should be routine vision screening, with diabetes listed as a secondary diagnosis. Failure to include the routine diagnosis or using an evaluation and management (E&M) procedure code may cause the claim to process as a diagnostic exam.

**For providers:**
CPT codes 99172 (visual function screening) and 99173 (visual acuity screening) are examinations considered to be an integral part of an office visit or well-child visit. CPT codes 99172 and 99173 cannot be separately reimbursed when billed with a well-child or E&M office visit (99381-99397), whether or not a -59 modifier is used. Providers may view the **TPM**, Chapter 7 for complete details.

## Diagnostic Exams

TRICARE covers diagnostic exams for the treatment of a confirmed or suspected eye condition. A diagnostic exam may be billed with E&M procedure codes like 992xx along with the appropriate diagnosis code identifying the patient's eye condition. A diabetes diagnosis could be the primary diagnosis or a secondary diagnosis. Diagnostic exams can be billed with eye exam CPT codes 92002, 92004, 92012, 92014, 92015, or the E&M codes.

# Global Maternity Claims

Global maternity involves the billing process for maternity-related beneficiary claims. After confirming that a patient is pregnant, all charges related to the pregnancy are grouped under one global maternity diagnosis code as the primary diagnosis. Figure 7.3 lists examples of these codes.

### Global Maternity Diagnosis Code Examples, Figure 7.3

| Code | Description |
|---|---|
| Z34.00 | Encounter for supervision of normal first pregnancy, unsp trimester |
| Z34.01 | Encounter for supervision of normal first pregnancy, first trimester |
| Z34.02 | Encounter for supervision of normal first pregnancy, second trimester |
| Z34.03 | Encounter for supervision of normal first pregnancy, third trimester |
| Z34.80 | Encounter for supervision of normal pregnancy, unsp trimester |
| Z34.81 | Encounter for supervision of normal pregnancy, first trimester |
| Z34.82 | Encounter for supervision of normal pregnancy, second trimester |
| Z34.83 | Encounter for supervision of normal pregnancy, third trimester |
| Z33.1 | Pregnant state, incidental |

When TRICARE Prime (TRICARE Prime, TPR, TYA Prime) beneficiaries are referred for specialty obstetric care, the primary care manager (PCM) submits a service request notification to HNFS. Professional and technical components of medically necessary fetal ultrasounds are covered outside of the maternity global fee. The medically necessary indications include but are not limited to, clinical circumstances that require obstetric ultrasounds to estimate gestational age, evaluate fetal growth, conduct a biophysical evaluation for fetal well-being, evaluate a suspected ectopic pregnancy, define the cause of vaginal bleeding, diagnose or evaluate multiple gestations, confirm cardiac activity, evaluate maternal pelvic masses or uterine abnormalities, evaluate suspected hydatidiform mole, and evaluate fetus condition in late registrants for prenatal care.

Maternal Serum Alpha Fetoprotein and Multiple Marker Screen Test are cost-shared separately (outside of the global fee) as part of the maternity care benefit to predict fetal developmental abnormalities or genetic defects. A second phenylketonuria test for infants is allowed if administered one to two weeks after discharge from the hospital, as recommended by the American Academy of Pediatrics.

## Claims for Mutually Exclusive Procedures

Mutually exclusive procedures are two or more procedures that are usually not performed during the same patient encounter on the same date of service. Generally, there is significant overlapping of services and duplication of efforts with mutually exclusive procedures. Mutual exclusivity rules also may include different procedure code descriptions for the same type of procedure, although only one procedure code applies.

For example, vaginal hysterectomy and abdominal hysterectomy are considered mutually exclusive.

## Physician-Administered Drug and Vaccine Claim Filing

The NDC number, drug quantity and package unit indicators are necessary on drug and vaccine claim filings when no nationally established TRICARE-allowable charge pricing has been set. Visit **www.health.mil** to determine if a TRICARE-allowable charge exists for specific drugs or vaccines. Where necessary, provide supporting documentation, such as the certificate of medical necessity (CMN), medical records or NDC information.

The following information must be included in the claim:

- An 11-digit NDC number, unique to the manufacturer of the drug. If an NDC number is only 10 digits, convert it to an 11-digit number when billing. (For example, convert 99999-9999-9 to 99999-9999-09). Always use the 5-4-2 format (five digits, four digits, two digits) on the claim. HNFS will deny claims without an NDC or with an incorrectly formatted NDC with the reason "NDC required."
- The corresponding CPT or HCPCS code.
- The drug quantity, which indicates the dosage of the immunization administered. This number always must be greater than zero but also can be a fractional or decimal unit (such as 0.5).
- The drug package indicator value (P = package, U = unit).
- The unit of measurement (UN = unit, ML = milliliter, ME = milligram, F2 = international unit, GR = gram).
- For vaccines supplied by a state agency or a state-run clinic, a code for administration of the vaccine with the modifier SL.

Use the following data elements to submit the NDC information in the HIPAA-standard ASC X12N 837 electronic claims format.

- Loop 2400, segment SV101 = CPT/HCPCS code
- Loop 2400, segment SV104 = CPT/HCPCS units
- Loop 2410, segment LIN03 = 11-digit NDC number
- Loop 2410, segment CPT04 = NDC quantity
- Loop 2410, segment CPT05 = NDC unit or basis for measurement code (UN, ML, ME, F2, GR)

Visit **www.wpc-edi.com** for detailed electronic filing instructions. If you need assistance mapping your NDC information to your EDI claim, contact our EDI Help Desk at **1-800-259-0264**.

**Note:** Providers in Alaska who submit paper claims must enter the NDC information in the shaded area of section 24 (A–G) of the 1500 claim form in the following order: qualifier (N4), NDC code, one space, unit of measurement, quantity. Visit the National Uniform Claim Committee's website at **www.nucc.org** for complete instructions.

***Washington state exception:*** *In accordance with the Washington State Childhood Vaccine Program, these billing guidelines do not apply to providers in the state of Washington. Please visit* **www.doh.wa.gov** *and* **www.wavaccine.org** *for Washington state vaccine billing guidelines.*

# Processing Claims for Out-of-Region Care

If you provide health care services to a TRICARE beneficiary who resides in or is enrolled in a different region, the beneficiary will pay the applicable cost-share, and you will submit reports and claims information to the region in which the TRICARE beneficiary is enrolled, not the region in which the beneficiary received care. If you have a claim issue or question regarding a TRICARE patient who normally receives care in another TRICARE region, call the appropriate region-specific number for assistance.

**TRICARE East Region (East Region): 1-800-403-3950 (Humana Military)**

The East Region includes the District of Columbia and the states of Alabama, Arkansas, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa (Rock Island Arsenal area only), Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri (St. Louis area only), New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas (excluding areas of Western Texas), Vermont, Virginia, West Virginia, and Wisconsin.

A complete list of claims mailing addresses, including those for TFL and TRICARE Overseas is available at **www.tricare-west.com**.

# Claims for Beneficiaries Assigned to US Family Health Plan-Designated Providers

Designated providers are facilities specifically contracted with the DOD to provide care to beneficiaries enrolled in the US Family Health Plan (USFHP). The USFHP is offered in six geographic regions in the United States. Although it provides a TRICARE Prime-like benefit, USFHP is a separately funded program that is distinct from the TRICARE program administered by HNFS. The designated provider is responsible for all medical care for a USFHP beneficiary, including pharmacy services, primary care and specialty care.

If you provide care to a USFHP beneficiary outside of the network or in an emergency situation, you must file claims with the appropriate designated provider at one of the addresses listed in Figure 7.4. Do not file USFHP claims with HNFS or PGBA). For more information visit the website at **www.usfhp.com.**

### USFHP Designated Providers, Figure 7.4

| |
|---|
| **Martin's Point Health Care**<br>PO Box 11410<br>Portland, ME 04104-5040 |
| **Brighton Marine Health Center**<br>PO Box 9195<br>Watertown, MA 02471-9195 |
| **US Family Health Plan at SVCMC**<br>PO Box 830745<br>Birmingham, AL 35283-0745 |
| **Johns Hopkins Medical Services Corporation**<br>6704 Curtis Court<br>Glen Burnie, MD 21060 |
| **CHRISTUS Health**<br>US Family Health Plan<br>ATTN: Claims<br>PO Box 924708<br>Houston, TX 77292-4708 |
| **Pacific Medical Clinics**<br>1200 12th Avenue South, Quarters 8/9<br>Seattle, WA 98144-2790 |

# TRICARE Overseas/Foreign Claims

International SOS is the claims processor for the TRICARE Overseas Program (TOP), TOP-Prime and TOP-Prime Remote. TOP Prime/TOP-Prime Remote enrollees require authorization for non-emergency care in the United States.

Use the contact information charts below to obtain the necessary authorization point-of-contact information. If filing a claim for an ADSM who is enrolled in a TOP option (TOP Prime, TOP-Prime Remote or TOP Select, submit the claim to the address listed in Figure 7.5. If filing a claim for a non-ADSM who is enrolled in a TOP option, refer to the addresses listed in Figure 7.6.

Overseas claims for National Guard and Reserve members on orders of 30 days or less should be sent to WPS. To expedite claims, the provider should submit a copy of the member's orders with the claim. The orders verify the member's eligibility for TRICARE benefits.

### Contact Information—ADSMs, Figure 7.5

| | |
|---|---|
| **All overseas areas** | **TRICARE Overseas (ADSM)**<br>PO Box 7968<br>Madison, WI 53707-7968<br>**Hotline: 1-877-451-8659**<br>**Fax: 1-215-773-2701**<br>**www.tricare-overseas.com** |

### TRICARE Overseas Claims Contact Information—Non-ADSMs, Figure 7.6

| | |
|---|---|
| **Africa**<br>(Africa, Europe and the Middle East) | **TRICARE Overseas**<br>Region 13<br>PO Box 8976<br>Madison, WI 53707-8976 |
| **TRICARE Latin America and Canada**<br>(Canada, the Caribbean basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands) | **TRICARE Overseas**<br>Region 15<br>PO Box 7985<br>Madison, WI 53707-7985 |
| **TRICARE Pacific**<br>(Asia, Guam, India, Japan, Korea, New Zealand, and Western-Pacific remote countries) | **TRICARE Overseas**<br>PO Box 7985<br>Madison, WI 53707-7985 |

**Claims for Beneficiaries Using Medicare and TRICARE For Life**

**Wisconsin Physicians Service (WPS)** – Military and Veterans Health is the claims processor for all TFL claims. If you currently submit claims to Medicare on your patient's behalf, you will not need to submit a claim to WPS. WPS has signed agreements with each Medicare carrier allowing direct, electronic transfer of TRICARE beneficiary claims to WPS. Claims processed by Medicare are submitted electronically to WPS. Beneficiaries and providers will receive an EOB from WPS after processing.

**Note:** Participating providers accept Medicare's payment amount. Nonparticipating providers do not accept Medicare's payment amount and are permitted to charge up to 115% of the Medicare-approved amount. Both participating and nonparticipating providers may bill Medicare.

When TRICARE is the primary payer, all TRICARE requirements apply. Refer to the **TRM**, Chapter 4 for details.

Figure 7.7 contains important contact information for you and your patients regarding Medicare and TRICARE claims.

### Medicare and TRICARE Claims Contact Information, Figure 7.7

| | |
|---|---|
| **Appeals** | **WPS/TRICARE For Life**<br>ATTN: Appeals, PO Box 7490<br>Madison, WI 53707-7490 |
| **Claims submission**<br>**Note:** Submit claims to Medicare first. | **WPS/TRICARE For Life**<br>PO Box 7890<br>Madison, WI 53707-7890 |
| **Customer service** | **WPS/TRICARE For Life**<br>PO Box 7889<br>Madison, WI 53707-7889 |
| **Online** | **www.TRICARE4u.com** |
| **Program Integrity** | **WPS/TRICARE For Life**<br>ATTN: Program Integrity, PO Box 7516<br>Madison, WI 53707-7516 |
| **Refunds** | **WPS/TRICARE For Life**<br>ATTN: Refunds, PO Box 7928<br>Madison, WI 53707-7928 |
| **Third-party liability** | **WPS/TRICARE For Life**<br>ATTN: TPL, PO Box 7897<br>Madison, WI 53707-7897 |
| **Toll-free telephone** | **1-866-773-0404** |
| **Toll-free TDD** | **1-866-773-0405** |

## Claims for Foreign Military Beneficiaries

Foreign military members and their family members in the United States may be eligible for TRICARE under an approved agreement (for example, reciprocal health care agreement, North Atlantic Treaty Organization [NATO] Status of Forces Agreement [SOFA], Partnership for Peace [PFP]. Foreign nations' armed forces members who are stationed in the United States or are guests of the U.S. Government may receive the same benefits as American ADSMs, including no out-of-pocket expenses for care directed by the military hospital or clinic. Eligible accompanying family members can receive outpatient services under TRICARE Select. A copy of the family member's identification card will have a foreign identification number or an actual SSN and indicate on the reverse "Outpatient Services Only."

Foreign family members do not need military hospital or clinic referrals prior to receiving outpatient services from network providers. Foreign family members follow the same pre-authorization requirements as TRICARE Select beneficiaries and are responsible for TRICARE Select deductibles and copayments/cost-shares. To collect charges for services not covered by TRICARE, you must have the foreign military family member agree, in advance and in writing, to accept financial responsibility for a non-covered service. Download a copy of the **Request for Non-Covered Services** form at **www.tricare-west.com**.

Claims for foreign military members and their family members should be filed electronically the same way other TRICARE claims are submitted. If claims are submitted by mail, submit to:

**Health Net Federal Services, LLC**
c/o PGBA, LLC/TRICARE
PO Box 202112
Florence, SC 29502-2113

TRICARE will not cover inpatient services for foreign military members. To be reimbursed for inpatient services, have the member make the appropriate arrangements with their national embassy or consulate in advance. Foreign military member eligibility is maintained in the Defense Enrollment Eligibility Reporting System (DEERS). Claims submission procedures are the same as for U.S. ADFMs in the United States.

## Claims for Civilian Health and Medical Program of the Department of Veterans Affairs

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is not a TRICARE program. For questions or general correspondence, you may contact CHAMPVA by any of the following means:

### CHAMPVA Contact Information, Figure 7.8

| | |
|---|---|
| **Telephone** | **1-800-733-8387** |
| **Mail** | VA Health Administration Center<br>CHAMPVA PO Box 469063<br>Denver, CO 80246-9063 |
| **Website** | **www.va.gov/COMMUNITYCARE/providers/info_ champva.asp** |

Claims for current treatment must be filed within 365 days of the date of service. Providers may file health care claims electronically on behalf of their patients. If you wish to file a paper health care claim, download CHAMPVA claim forms from the CHAMPVA website, and file them within the one-year claim-filing deadline.

Send the claim to:

**VA Health Administration Center CHAMPVA**
PO Box 469064
Denver, CO 80246-9064

You may submit a written appeal if exceptional circumstances prevent you from filing a claim in a timely fashion. Send written appeals to:

**VA Health Administration Center CHAMPVA**
ATTN: Appeals
PO Box 460948
Denver, CO 80246-0948

**Note: *Do not send appeals to the claims-processing address*.** This will delay your appeal. If your CHAMPVA claim is misdirected to PGBA, LLC (PGBA), PGBA will forward CHAMPVA claims to the CHAMPVA VA Health Administration Center in Denver, within 72 hours of identifying the CHAMPVA claim. A letter will be sent to the claimant informing him or her of the transfer. The letter includes instructions on how to submit future CHAMPVA claims and to direct any correspondence for CHAMPVA beneficiaries to the CHAMPVA Department of Veterans Affairs (VA) Health Administration Center.

# Claims for the Continued Health Care Benefit Program

Humana Military is the contractor for the Continued Health Care Benefit Program (CHCBP) and has partnered with WPS for CHCBP claims processing. HNFS does not administer this program.

CHCBP beneficiaries may request providers file medical claims on their behalf.

Submit CHCBP claims to:

**TRICARE East Region Claims**
PO Box 8923
Madison, WI 53707-8923

For more information about CHCBP, including eligibility verification, visit **HumanaMilitary.com** or call Humana Military at **1-800-444-5445**.

# Claims for the Extended Care Health Option

All claims for the Extended Care Health Option (ECHO) must have an authorization, even if the beneficiary has other health insurance.

All claims for ECHO-authorized care (including ECHO Home Health Care) should be billed on individual line items. Unauthorized ECHO care claims will be denied.

ECHO claims will be reimbursed for the amount authorized (by HNFS) or the monthly or fiscal year benefit limit, whichever is lower. Each line item on an ECHO claim needs to correspond to a line item on the service authorization, or the claim may be denied or delayed due to research and reconciliation.

The billed amount for procedures should reflect the service, not the applicable ECHO benefit limits. Pricing of ECHO services and items is determined in accordance with the **TRM**. Refer to the **TPM**, Chapter 9 and the **TOM**, Chapter 18 for additional claims information.

# Autism Care Demonstration Billing

Visit our **Autism Care Demonstration (ACD)** pages for assistance with determining appropriate billing codes when providing services under TRICARE's ACD. All applied behavior analysis (ABA) services require pre-authorization, even if the beneficiary has OHI.

## Rendering Provider

The rendering provider who actually provided the ABA services must be indicated in Box 24J of the 1500 claim form to ensure proper ABA claims processing. The rendering provider may be different than the billing provider or billing group. For example, behavior technicians who provide services under the supervision of an authorized Board Certified Behavior Analyst (BCBA) must be indicated as the rendering provider if they performed the service.

# Claims for TRICARE Reserve Select, TRICARE Retired Reserve and TRICARE Young Adult

All beneficiaries covered under TRS and TRR follow the applicable TRICARE Select cost-shares, copayments, deductibles, and catastrophic caps. TRS cost-shares follow the applicable cost-shares, deductibles and catastrophic caps for ADFMs. TRR cost-shares, deductibles and catastrophic caps match retiree cost-shares.

All beneficiaries covered under TYA Select or TYA Prime should follow the applicable cost-shares, copayments, deductibles, and catastrophic caps based on sponsor status and TYA plan option.

## TRICARE Network Providers

- File claims with PGBA electronically for TRS, TRR and TYA members just as you would file other TRICARE claims.
- Submit claims using XPressClaim via **www.tricare-west.com**.
- The cost-share for all TRS members, including National Guard and Reserve members, is 15% of the negotiated fee for covered services from TRICARE network providers. TRICARE will reimburse the remaining amount of the negotiated fee.

The cost-share for all TRR-covered members is 20% of the negotiated fee for covered services from TRICARE network providers. TRICARE will reimburse the remaining amount of the negotiated fee.

### TRICARE-Authorized Non-Network Providers

- Participation with TRICARE (that is, accepting assignment, filing claims and accepting the TRICARE-allowable charge as payment in full) is encouraged but not required for TRS, TRR and TYA claims.
- Non-network providers are encouraged to submit their TRICARE claims electronically.
- The cost-share for all TRS-covered members is 20% of the TRICARE-allowable charge for covered services from non-network TRICARE-authorized providers. TRICARE will reimburse the remainder of the TRICARE-allowable charge.
- The cost-share for all TRR-covered members is 25% of the TRICARE-allowable charge for covered services from network TRICARE-authorized providers. TRICARE will reimburse the remainder of the TRICARE-allowable charge.
- If a non-network provider does not participate on a particular claim, beneficiaries will file their own reimbursement claims with TRICARE and then pay the non-network provider.

**Note (for non-network providers):** By federal law, if a non-network provider does not participate on a particular claim, the provider may not charge more than 15% (115%) above the TRICARE-allowable charge. The TRICARE-allowable charge schedules can be found at **www.health.mil/rates**.

## Supplemental Health Care Program Claims

The SHCP covers any civilian health care service as long as either the military hospital or clinic refers the patient or the Medical Management Support Office at Defense Health Agency, Great Lakes (DHA-GL)/Specialized Authorization Staff (SAS) authorizes the care.

Claims for SHCP are processed and paid through HNFS/PGBA. SHCP claims must be submitted electronically or mailed to the address below:

**Health Net Federal Services, LLC**
c/o PGBA, LLC/TRICARE
PO Box 202100
Florence, SC 29502-2100

The same balance billing limitations applicable to TRICARE apply to the SHCP. For more information regarding balance billing, refer to "***Balance Billing***" in the ***Important Provider Information*** section of this handbook.

## TRICARE and Other Health Insurance

### Active Duty Service Members

ADSMs – including activated National Guard and Reserve members – cannot use OHI as their primary insurance. TRICARE is the primary payer and coordination of benefits with OHI carriers does not occur.

ADSMs who have OHI require an approval from HNFS for all services.

### All Other Beneficiary Categories

Beneficiaries must use OHI before TRICARE. Health coverage through an employer, an association, a private insurer, school health care coverage for students, and Medicare are always primary to TRICARE. Even health care through an auto insurance plan is considered OHI when services are related to an auto accident.

**Exceptions are:** Medicaid, State Victims of Crime Compensation Programs, the Indian Health Service, or other programs or plans as identified by DHA.

Services must be provided by a TRICARE-authorized provider, and all requirements of the OHI plan must be followed. If the OHI denies a claim because OHI authorization requirements were not followed or because a network provider was not used, TRICARE will deny the claim, and the patient will be responsible for the denied charges.

The OHI must process the claim before TRICARE can consider the charges.

If the OHI denies the claim as not medically necessary, all appeal rights with the OHI must be used before TRICARE can process the claim. TRICARE benefits only can be considered after all avenues of appeal available with the OHI have been pursued.

TRICARE may become the primary payer if OHI benefits are exhausted or if the primary OHI does not cover a service or supply. If TRICARE becomes the primary payer, additional pre-authorization requirements may apply.

### Other Health Insurance Claims

*Identify OHI in the claim form*

- Mark "Yes" in Box 11d (1500 claim form) or FL (UB-04).
- Indicate the primary payer in Box 9 (1500 claim form) or FL 50 (UB-04).
- Indicate the amount paid by the OHI in Box 29 (1500 claim form) or FL 54 (UB-04).
- Indicate insured's name in Box 4 (1500 claim form) or FL 58 (UB-04).
- Indicate the allowed amount of the OHI in FL 39 (UB04) using value code 44 and entering the dollar amount.

*Payment guidelines*

- If TRICARE is the secondary payer, submit the claim to the primary payer first. If the claim processor's records indicate that the beneficiary has one or more primary insurance policies, submit explanation of benefit (EOB) information from other insurers along with the TRICARE claim.
- HNFS/PGBA will coordinate benefits when a claim has all of the necessary information (for example, billed charges, beneficiary's copayment and OHI payment). For HNFS/PGBA to coordinate benefits, the EOB must reflect the patient's liability (copayment and/or cost-share), the original billed amount, the allowed amount, and/or any discounts. If the EOB indicates that a primary carrier has denied a claim due to failure to follow plan guidelines or utilize network providers, TRICARE also will deny the claim.

TRICARE does not always pay the beneficiary's copayment or the balance remaining after the OHI payment. However, the beneficiary liability is usually eliminated. The beneficiary should not be charged the cost-share when the TRICARE EOB shows no patient responsibility. Payment calculations differ by provider status as detailed below. With TRICARE network providers and non-network providers that accept TRICARE assignment, TRICARE pays the lesser of:

- The billed amount minus the OHI payment,
- The amount TRICARE would have paid without OHI, or
- The beneficiary's liability (OHI copayment, cost-share, deductible, etc.).

Non-network providers who do not accept TRICARE assignment may only bill the beneficiary up to 115% of the TRICARE-allowable charge. If the OHI paid more than 115% of the allowed amount, no TRICARE payment is authorized, the charge is considered paid in full and the provider may not bill the beneficiary. If the service is not covered by TRICARE, the beneficiary may be liable for these charges. TRICARE pays the lesser of:

- 115% of the allowed amount minus the OHI payment,
- The amount TRICARE would have paid without OHI, or
- The beneficiary's liability (OHI copayment, cost-share, deductible, etc.).

When working with OHI, all TRICARE providers should keep in mind TRICARE will not pay more as a secondary payer than it would have as a primary payer. **Point-of-service** cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. However, the beneficiary must have pre-authorization for inpatient mental health services, regardless of whether the beneficiary has OHI.

In some cases, the TRICARE Summary Payment Voucher/Remit will state, "Payment reduced due to OHI payment," and there may be no payment and no beneficiary liability. The TRICARE cost-share (the amount of cost-share that would have been taken in the absence of primary insurance) is indicated on the TRICARE Summary Payment Voucher/Remit only to document the amount credited to the beneficiary's catastrophic cap.

**Note:** For EDI claims, visit **www.tricare-west.com**.

# TRICARE and Third-Party Liability Insurance

The Federal Medical Care Recovery Act allows the government to be reimbursed for costs associated with treating a TRICARE beneficiary who has been injured in an accident caused by someone else.

When a claim appears to have possible third-party involvement, certain necessary actions can affect total processing time. HNFS is responsible for identifying and investigating all potential third-party recovery claims.

Inpatient claims submitted with ICD-10 S and T diagnosis codes ending with the seventh character of A (with some exclusions, as listed in Figure 7.10), regardless of the billed amount, and claims for professional services that exceed a TRICARE liability of $500 that indicate an accidental injury or illness, will not be processed further until the beneficiary completes and submits a Statement of Personal Injury–Possible Third Party Liability (DD Form 2527).

There are certain diagnosis codes that are exceptions. A DD Form 2527 is not required for certain diagnosis codes, specifically those listed in Figure 7.9.

### ICD-10 Diagnosis Codes Exceptions/Exclusions, Figure 7.9

| | |
|---|---|
| S00.02–S00.97 | S60.32–S60.879 |
| S10.1–S10.97 | S70.22–S70.379 |
| S20.1–S20.9 | S80.22–S80.879 |
| S30.82–S30.877 | S90.42–S90.879 |
| S40.22–S40.879 | T15.1 |
| S50.32–S50.879 | T16 |

When a claim is received that appears to have possible third-party involvement, the following process will occur:

- The DD Form 2527 will be mailed to the beneficiary.
- The claim is suspended for up to 35 calendar days, during which time the beneficiary is expected to complete and return the form.
- If the DD Form 2527 is not received within 35 calendar days, the claim will be denied and "Requested third party liability information not received" will appear on the explanation of benefits (EOB).
- The claim will be reprocessed once the beneficiary completes and returns the DD Form 2527. Encourage the beneficiary to fill out, sign and return the form within the 35 calendar day time frame to avoid payment delays.
- If the illness or injury was not caused by a third party but the diagnosis code(s) indicates an accidental injury or illness, the beneficiary is still responsible for filling out, signing and returning DD Form 2527. If the form is not returned, the claim will be denied, and you may bill the beneficiary.

If you believe a patient needs to complete the DD Form 2527 based on the information above, it is appropriate to have copies of the form on hand for the patient to complete. Taking this precautionary step can help expedite the claim-submission process and ensure timely reimbursement. The **Statement of Personal Injury–Possible Third Party Liability** (DD Form 2527) is available on **www.tricare-west.com**. Fax completed forms to **1-844-869-2813**.

# TRICARE and Workers' Compensation

TRICARE will not share costs for services for work-related illnesses or injuries covered under workers' compensation programs.

# Avoiding Collection Activities

Both network and non-network providers are encouraged to explore every possible means to resolve claims issues without involving debt collection agencies. In cases where the claim has been denied, payment has been reduced or is pending, visit **www.tricare-west.com** to check the status of the claim. Also, you may request a review in writing.

Network providers are to accept the TRICARE-allowable charge as payment in full for covered services. Refer to the ***Important Provider Information*** section of this handbook for additional information about provider and beneficiary payment responsibilities.

Beneficiaries are responsible for their out-of-pocket expenses reflected on the TRICARE Summary Payment Voucher/Remit, including deductible, cost-share and/or copayment amounts.

## TRICARE's Debt Collection Assistance Officer Program

Debt Collection Assistance Officers (DCAO) are located at each TRICARE Regional Office and military hospital or clinic to assist TRICARE beneficiaries with collection-related issues. DCAOs cannot provide beneficiaries with legal advice or fix their credit ratings but can help beneficiaries through the debt collection process by providing documentation for the collection or credit reporting agency explaining the circumstances relating to the debt. Beneficiaries can access the DCAO directory via **www.tricare.mil**.

When meeting with a DCAO, beneficiaries must take or submit documentation (for example, debt collection letters, EOBs and medical/dental bills from providers) associated with a collection action or adverse credit rating.

The more information the beneficiary provides, the less time it will take to determine the problem's cause. The DCAO will research the beneficiary's claim with the appropriate claims processor or other agency points of contact and provide the beneficiary with a written resolution to the collection problem. The DCAO will notify the collection agency that action is being taken to resolve the issue.

# TRICARE Claim Disputes

In the event you disagree with reimbursement rates, you may request a claim review (TRICARE-allowable charge review). A claim review differs from an appeal, which is only for charges denied as "not covered" or not "medically necessary."

The following subsections detail the appropriate types of review requests, time frames for submitting requests, contact information, and the information to include with requests. By following the rules and timelines for requesting reviews, you can help resolve your request promptly.

## Claims Adjustments and Allowable Charge Reviews

An allowable charge review can be requested by a provider or beneficiary if either party disagrees with the reimbursement allowed on a claim. This includes a review of unlisted procedures.

The following issues are considered reviewable:

- Allowed amount disputes
- Charges denied as "Included in a paid service"
- Charges denied as "Requested information not received"
- Claim denied as "Provider not authorized"
- ClaimsXten™ denials
- Coding issues
- Cost-share and deductible issues
- Eligibility denials
- Other health insurance (OHI) issues
- Penalties for no authorization
- **Point-of-service** option disputes

  (**Exception:** The **point-of-service** option for emergency services is appealable)
- Third-party liability issues
- Timely filing limit denials
- Wrong procedure code



## How to Request a Claim Review

Your request must be postmarked or received by HNFS within 90 calendar days of the date on the beneficiary's TRICARE EOB or the TRICARE Summary Payment Voucher/Remit.

Include the following:

- Letter with the reason for requesting the claim review
- Copy of the claim if available
- Copy of the EOB or TRICARE Summary Payment Voucher/Remit
- Supporting medical records any new information that was not submitted with the original claim

Submit the request to:

**Health Net Federal Services, LLC**
c/o PGBA, LLC/TRICARE
TRICARE West – Claims Correspondence
PO Box 202100
Florence, SC 29502-2100
**Fax: 1-844-869-2812**

## Network Provider Disputes Relating to Contractual Reimbursement Amount

Network providers who believe they have been reimbursed at less than the agreed-upon rate should fax a request for review to **1-844-836-5818**.

Submit the request for review within 90 calendar days of the date of the TRICARE EOB or TRICARE Summary Payment Voucher/Remit relating to the alleged underpayment. The request should identify, in detail, why you believe the reimbursement amount is incorrect.

Failure to submit a request for review within these parameters and within this time frame constitutes a waiver of any such claim.

## Appeals and Administrative Reviews of Claims Denials

The following are considered appealable issues:

- Claims denied because the service is not covered under TRICARE or exceeds policy limitations/coverage criteria.
- Claims denied as not medically necessary.
- Claims for assistant surgeon charges denied by ClaimsXten.
- Claims processed as **point-of-service** only when the reason for dispute is that the service was for emergency care.

**Note:** Network providers must hold the beneficiary harmless for non-covered care. Under TRICARE's hold harmless policy, the beneficiary has no financial liability and, therefore, has no appeal rights. However, if the beneficiary has waived hold harmless rights, the beneficiary may be financially liable and further appeal rights may be offered. Refer to the *"**Informing Beneficiaries about Non-Covered Services**" and "**TRICARE's Hold Harmless Policy**"* in the ***Important Provider Information*** section of this handbook.

Appeal and administrative review requests must be postmarked or received within 90 calendar days of the date of the denial. For TRICARE purposes, a postmark is a cancellation mark issued by the U.S. Postal Service. If the postmark on the envelope is not legible, the date of receipt is deemed to be the date of the filing.

Providers may mail appeal and review requests to:

**Health Net Federal Services, LLC**
TRICARE Claims Appeal
PO Box 8008
Virginia Beach, VA 23450-8008

For more detailed information about the appeals process, visit the **HNFS Claim Appeals** page. When filing appeals, keep the following in mind:

- All appeal/administrative review requests must be in writing and signed.
- All appeal/administrative review requests must state the issue in dispute.
- All appeal/administrative review requests must include a copy of the initial denial (EOB/provider remittance advice) and any additional documentation in support of the appeal.

Additionally, provide the following information with your appeal:

- Sponsor's SSN or DBN
- Beneficiary's/patient's name
- Date(s) of service
- Provider's address, telephone/fax numbers and email address (if available)
- Statement of the facts of the request

Appeals must be requested by an appropriate appealing party. A signed **Appointment of Representative for an Appeal** form may be required if applicable.

## Who can appeal a denied claim?

- The patient may appeal, except if services were by a network provider. (Network providers cannot bill patients for non-covered services or services denied as not medically necessary.)
- The parent or legal guardian of a minor child may appeal, except if services were from a network provider.
- A network provider can appeal services they performed.
- A non-network provider can appeal services performed if the non-network provider accepted assignment on the claim.
- A network provider may appeal a claim on his/her own behalf if the denied claim is appealable per the remittance notice.
- Legally appointed representatives may appeal. Appeals submitted by anyone other than the above will not be accepted unless the individual has been appointed as a representative by power of attorney or an **Appointment of Representative for an Appeal** form has been submitted.
- An attorney may submit an appeal if acting on behalf of an appropriate appealing party.

# TRICARE Reimbursement Methodologies

## TRICARE Reimbursement Methodologies

The Defense Appropriations Act established the uniform payment system for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), called the TRICARE CHAMPUS maximum allowable charge (CMAC). When TRICARE was implemented, the TRICARE Enabling Statute (**Title 10, United States Code, Section 1079**[h][1]) gave the secretary of defense the authority to set the reimbursement rates for health care services provided to TRICARE beneficiaries. Those rates are set in accordance with the same reimbursement rules that apply to payments for similar services under Medicare (Title XVIII of the Social Security Act [**Title 42, United States Code, Section 1395**]).

Reimbursement rates and methodologies are subject to change per Department of Defense (DOD) guidelines. Refer to the **TRICARE Reimbursement Manual (TRM)** for more details. Health Net Federal Services (HNFS) offers payments and remittances by National Provider Identifier (NPI) number. The NPI billed on the claim will determine where payment and remittance will be sent.

## Reimbursement Limit

Payments made to network providers for medical services rendered to TRICARE beneficiaries will not exceed 100% of the TRICARE-allowable charge. All reimbursement methodologies discussed in this chapter are impacted by a network provider's negotiated discount rate. A network provider will not receive 100% of the TRICARE-allowable charge if they have a negotiated discount. Nonparticipating, non-network providers may not bill TRICARE beneficiaries more than 115% of the TRICARE-allowable charge.

If you believe the claim reimbursement amount is incorrect, you should follow the allowable charge review process explained in "***TRICARE Claim Disputes***" in the ***Claims Processing and Billing Information*** section of this handbook.

## TRICARE CHAMPUS Maximum Allowable Charge

The CMAC is the maximum amount TRICARE will reimburse for nationally established procedure coding (that is, codes for professional services). Updated CMAC rates based on site of service are available at **www.health.mil/rates**. Periodic CMAC changes apply to both network and non-network providers.

### Site-of-Service Pricing Categories

TRICARE CMAC changes vary per the Defense Health Agency's (DHA) discretion.

The following represent the four categories of providers used for reimbursement:

**Category one:** Services of doctors of medicine (MD), doctors of osteopathic medicine (DO), optometrists, podiatrists, psychologists, oral surgeons, certified nurse midwives, and audiologists provided in facilities, including hospitals (both inpatient and outpatient and billed with the appropriate revenue and procedure code for the outpatient department where the services were rendered), residential treatment centers (RTC), ambulances, hospices, military hospitals and clinics, mental health care facilities, community mental health care centers (CMHC), skilled nursing facilities (SNF), ambulatory surgical centers (ASC), etc.

**Category two:** Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, certified nurse midwives, and audiologists provided in non-facility settings, including provider offices, home settings and all other non-facility settings.

**Category three:** Services of all other providers not included in category one that are provided in facilities, including hospitals (both inpatient and outpatient and billed with the appropriate revenue code for the outpatient department where the services were rendered), RTCs, ambulances, hospices, military hospitals and clinics, mental health care facilities, CMHCs, SNFs, ASCs, etc. The non-facility CMAC rate applies to occupational therapy (OT), physical therapy (PT) and speech therapy (ST) regardless of the setting.

**Category four:** Services, of all other providers not included in category two, that are provided in non-facility settings, including provider offices, home settings and all other non-facility settings. The non-facility CMAC rate applies to OT, PT and ST, regardless of the setting.

### Accessing TRICARE CMAC Rates

Find the TRICARE CMAC rates at **www.health.mil/rates** and follow the online prompts. For CMAC rates from previous years, use the applicable Current Procedural Terminology (CPT) code.

## TRICARE-Allowable Charge

The TRICARE-allowable charge is the maximum amount TRICARE will authorize for TRICARE-covered medical and other services furnished in an inpatient or outpatient setting. The TRICARE-allowable charge is normally the lesser of the:

a. Actual billed charge,

b. CMAC or,

c. Prevailing charge (or amount derived from a conversion factor) made for a given procedure, adjusted to reflect local economic conditions as detailed in the **TRM**.

For example:

- If the TRICARE-allowable charge for a service is $90 and the billed charge is $50, the TRICARE-allowable charge becomes $50 (the lesser of the two charges).
- If the TRICARE-allowable charge for a service is $90, and the billed charge is $100, TRICARE will allow $90 (the lesser of the two charges).
- In the case of inpatient hospital payment, the hospital-specific reimbursement method applies (for example, diagnosis-related group [DRG] rate or mental health care per diem is the TRICARE-allowable charge regardless of the billed amount, unless otherwise stated in the provider's contract).
- In the case of outpatient hospital claims subject to the TRICARE Outpatient Prospective Payment System (OPPS), services will be subject to OPPS ambulatory payment classifications (APCs), where applicable.

**Note:** A network provider acknowledges and agrees that the maximum amount reimbursed for services provided by the network provider under a TRICARE provider agreement is prescribed by TRICARE/CHAMPUS regulations as published in the Federal Register, and regardless of what is stated in the TRICARE Provider Agreement and/or the Compensation Schedule, the network provider shall not receive or accept any reimbursement in excess of the TRICARE CMAC, as determined by the category or type of provider the network provider was per the TRICARE/CHAMPUS regulations at the time covered services were rendered.

## State Prevailing Rates

State prevailing rates are established for codes that have no current available CMAC pricing. Prevailing rates are those charges that fall within the range of charges most frequently used in a state for a particular procedure or service. When no TRICARE-allowable charge is available, a prevailing charge is developed for the state in which the service or procedure is provided.

In lieu of a specific exception, prevailing profiles are developed on a:

- Statewide basis (localities within states are not used, nor are prevailing profiles developed for any area larger than individual states).
- Non-specialty basis.

Prevailing profiles are developed using a minimum of eight claims submitted for reimbursement to TRICARE. All actual charges billed for the service are put in ascending order, and the lowest charge (in the array) that is high enough to include 80 percent of the cumulative charges (number of claims billed) becomes the prevailing charge. For more details, refer to **TRM**, Chapter 5. TRICARE policy directs an annual update will be performed on all current state prevailing rates. For more details, refer to **TRM**, Chapter 5.

## Ambulance Rates

TRICARE adopts Medicare's Ambulance Fee Schedule (AFS) as the CMAC for ambulance services. TRICARE will follow **Medicare Claims Processing Manual**, Chapter 15, and reimbursement shall be based on Medicare's AFS. The **AFS** is provided on the **Centers for Medicare & Medicaid Services (CMS)** website. Also refer to **Air Ambulance** in this section of the handbook.

Payment under the AFS:

- Includes a base rate payment plus a separate payment for mileage,
- Covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with such transport, and
- Does not include a separate payment for items and services furnished under the ambulance benefit.

All claims for services must include the ZIP code for the point-of-pickup.

Payments for items and services are included in the fee schedule payment.

For more information about ambulance services, refer to the **TRM**, Chapter 1.

### Air Ambulance

Air ambulance services shall be paid the greater of the Medicare AFS or the TRICARE provisional air ambulance CMAC. Use the following guidelines when billing for air ambulance services:

- Submit air ambulance claims based on the point-of-pickup ZIP code.
- Bill each leg of the trip separately based on the point-of-pickup ZIP code for each leg.

Each claim only should contain services that originated within the same point of pickup. Providers must prepare a separate claim for each trip (ground or air) if points of pickup are in different ZIP codes.

For ambulance service claims, institutional-based providers must report an origin and destination modifier for each ambulance trip provided in HCPCS/rates.

Generally, each ambulance trip will require two lines of coding – one line for the service and one line for the mileage. Providers who do not bill mileage would have one line of code for the service. Air ambulance services may be paid only for ambulance services to a hospital.

### Paramedic Intercept Services

Paramedic intercept services are advanced life support (ALS) services provided by an entity that does not provide ambulance transport. These services most often are provided when a local volunteer ambulance providing only basic life support (BLS) services transfers a patient in need of ALS. An ALS paramedic is then dispatched to provide services to the patient, either at the scene or once the ambulance is on the way to the hospital. Paramedic intercept services may be payable under TRICARE separate from the ambulance transport if the following requirements are met:

- The services are provided in a rural area, as designated by state law or regulation. (The current list of rural areas is periodically published in the Federal Register.)
- The patient's medical condition requires ALS services such as electrocardiogram (also referred to as ECG or EKG) monitoring, chest decompression or intravenous therapy that cannot be provided by BLS ambulance paramedics.
- The services are furnished under a contract with one or more volunteer ambulance services.

The volunteer ambulance service involved must:

- Meet the program's certification requirements for furnishing ambulance services,
- Furnish services at the BLS level only at the time of the intercept, and
- Be prohibited by state law from billing anyone for any service.

### Joint-Response Reimbursement

In situations where a BLS ambulance provides the transport of a TRICARE beneficiary and an ALS paramedic provides medically necessary services that meet the above criteria, the BLS ambulance supplier may bill TRICARE the ALS rate if an agreement between the BLS and ALS exists, and a copy of the agreement is provided with the claim.

TRICARE covers joint-response services from TRICARE-authorized providers.

- Paramedics cannot bill as individual providers; however, ambulance companies can.
- The ALS services must be medically necessary.
- Providers must bill using either:
  - S0207 – paramedic intercept, non-hospital-based ALS service (non-voluntary), non-transport; or
  - S0208 – paramedic intercept, hospital-based ALS service (non-voluntary), non-transport.

**Note:** Codes may change over time. See **TRM**, Chapter 1, Section 14, for the most current codes.

The reimbursement rate will match Medicare's rate for code A0432 (paramedic intercept, rural area, transport furnished by a volunteer ambulance company that is prohibited by state law from billing third party payers).

### Treat-and-Release

Treat-and-release situations occur when an ambulance responds to a call and provides medical services, but the ambulance doesn't transport the patient.

TRICARE covers treat-and-release services from TRICARE-authorized providers when all the following conditions are met:

- Paramedics cannot bill as individual providers; however, ambulance companies can.
- The services were medically necessary based on the condition of the beneficiary receiving the ambulance service.
- Failure to provide transport resulted from either a determination the patient's condition had stabilized and transport to the hospital was no longer required, or the patient refused transport after receiving services.
- Ambulance entity must bill using A0998. The reimbursement rate will match Medicare's rate for code A0428 (BLS non-emergency).

**Note:** Codes may change over time. See **TRM**, Chapter 1, Section 14, for the most current codes.

## Ambulatory Surgery Center (ASC)

Hospital-based surgery procedures are reimbursed under OPPS (for hospitals that are subject to OPPS). TRICARE adopted Medicare's ambulatory surgery center (ASC) reimbursement system for freestanding ASCs, including ASC fee schedule rules, payment rates, payment indicators, list of covered procedures and ancillary services, and wage indices. Providers may view the full list of ASC reimbursement on the CMS website at **https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment**.

### Freestanding Ambulatory Surgery Center Charges

Effective Oct. 1, 2023, freestanding ASCs are reimbursed the lesser of CMS' ASC payment rate (or negotiated rate, if applicable) or billed charge. Payment rates only apply to facility charges for ambulatory surgery in a freestanding ASC.

Surgical procedures covered under TRICARE but not on the CMS ASC list of covered procedures will reimburse professional services to the rendering provider based on allowable charge methodology. Separate payment will not be made for facility charges. Refer to **TRM**, Chapter 3, Section 1 and **TRM** Chapter 5 for additional information on payment of individual professional services.

Facility charges for covered services listed on the CMS ASC list will be reimbursable with exception to CPT code 41899 and certain dental procedures. CPT code 41899 will reimburse the ASC facility at the OPPS rate. For more information about dental care coverage in an ASC, refer to **TRM**, Chapter 8, Section 13.2.

Covered procedures will reimburse based on national rates established by the CMS ASC list and will be wage-adjusted for geographic wage variations. Corneal tissue acquisition, drugs and devices with pass-through status under OPPS, brachytherapy sources, intraocular lenses (IOLs) and new technology IOLs, and separately payable drugs and biologics will not be geographically wage adjusted.

All hospitals or freestanding ASCs must submit claims for surgery procedures on a UB-04 claim form. Hospital-based ASC providers must use Type of Bill 13X.

### Multiple Procedures

Multiple ambulatory surgeries are processed according to multiple surgery guidelines and will reimburse:

- One hundred percent of the payment amount for the procedure subject to discounting with the highest TRICARE-allowable charge (only one procedure on an outpatient episode is paid at 100%) unless the specific procedure is listed in the CPT as a modifier 51 exempt or add-on code.
- Fifty percent of the TRICARE-allowable charge for each of the other procedures subject to discounting performed during the same session.

Providers will not be reimbursed for incidental surgical procedures clinically integral to the performance of the primary procedure that are performed during the same operative session in which other covered surgical procedures were performed. (An incidental surgical procedure is one that is performed at the same time as a more complex primary surgical procedure.)

Incidental procedures only will be reimbursed if required for surgical management of multiple traumas or if involving a major body system different from the one served by the primary surgery.

Refer to **TRM** Chapter 13, Section 3 (Discounting for Bilateral Procedures) and **TRM** Chapter 1, Section 3 (Unbundling of Procedure Codes).

## Anesthesia Claims and Reimbursement

Professional anesthesia claims must be submitted on a Health Insurance Claim Form (1500), using the applicable CPT anesthesia codes. If applicable, bill the claim with the appropriate physical status (P) modifier and, if appropriate, other optional modifiers.

An anesthesia claim must specify who provided the anesthesia. In cases where a portion of the anesthesia service is provided by an anesthesiologist and a nurse anesthetist performs the remainder, the claim must identify exactly which provider performed each service and may include modifiers to make this distinction.

### Anesthesia Rates

TRICARE calculates anesthesia reimbursement rates using the number of time units, the Medicare relative value units (RVU) and the anesthesia conversion factor.

### Calculating Anesthesia Reimbursement

The following formula is used to calculate the TRICARE anesthesia reimbursement:

(time units + RVUs) × anesthesia conversion factor

**Base unit** – TRICARE anesthesia reimbursement is determined by calculating a base unit derived from the American Society of Anesthesiologist's Relative Value Guide, plus an amount for each unit of time the anesthesiologist is in attendance (in the beneficiary's presence).

A base unit includes reimbursement for:

- Examination of the beneficiary performed preoperatively.
- Administration of fluids and/or blood products incidental to anesthesia care.
- Interpretation of non-invasive monitoring (for example, electrocardiogram [also referred to as ECG or EKG], temperature, blood pressure, pulse oximetry, capnography, and mass spectrometry).
- Determination of required dosage/method of anesthesia.
- Induction of anesthesia.
- Follow-up care for possible postoperative anesthesia-related effects on the beneficiary.

Services not included in the base value include:

- Placement of arterial, central venous and pulmonary artery catheters.
- Use of transesophageal echocardiography.

When multiple surgeries are performed, only the RVUs for the primary surgical procedure are considered, while the time units should include the entire surgical session.

**Note:** This does not apply to continuous epidural analgesia.

**Time unit** – Time units are measured in 15-minute increments and any fraction of a unit is considered a whole unit. Anesthesia time starts when the anesthesiologist begins to prepare the beneficiary for anesthesia care in the operating room or in an

equivalent area. It ends when the anesthesiologist is no longer in personal attendance, and the beneficiary may be safely placed under post-anesthesia supervision. On the 1500 claim form, the DUTs in column 24G should always be 1 unit per procedure. Indicate the anesthesia administration start and stop times on the 1500 claim form. For electronic data interchange (EDI) claims, please indicate the total anesthesia minutes in loop and segment 2400/SV104.

**Conversion factor** – The sum of the time units and RVUs is multiplied by a conversion factor. Conversion factors between physician and non-physician providers can vary by state, based on local wage indexes.

For more specific information on anesthesia reimbursement calculation and methodologies, refer to the **TRM**.

### Anesthesia Procedure Pricing Calculator

Use the Anesthesia Procedure Pricing tool at **www.health.mil** to determine anesthesia rates.

## Applied Behavior Analysis

Applied behavior analysis (ABA) reimbursement rates are based on independent analyses of commercial and CMS ABA rates and also vary by geographic locality. Visit **Applied Behavior Analysis Maximum Allowed Amounts** to learn more.

## Assistant Surgeon Services

TRICARE policy defines an assistant surgeon as any TRICARE-authorized physician, dentist, podiatrist, certified physician assistant (PA), nurse practitioner (NP), or certified nurse midwife acting within the scope of license who actively assists an operating surgeon with a covered surgical service. Reimbursement for assistant surgeon services will be the lesser of a billed charge or 16% of the prevailing charge for the surgery involved.

TRICARE covers assistant surgeon services when the services are considered medically necessary and meet the following criteria:

- The complexity of the surgical procedure warrants an assistant surgeon rather than a surgical nurse or other operating room personnel.
- Interns, residents or other hospital staff are unavailable at the time of the surgery.

When billing for assistant surgeon services, please note:

- All assistant surgeon claims are subject to medical review and medical-necessity verification.
- Standby assistant surgeon services are not reimbursed when the assistant surgeon does not actively participate in the surgery.
- The PA or NP must actively assist the operating surgeon as an assistant surgeon and perform services that are authorized as a TRICARE benefit.
- When billing for a procedure or service performed by a PA, the supervising or employing physician must bill the procedure or service as a separately identified line item (for example, PA office visit) and use the PA's provider number.
- The supervising or employing physician of a PA must be a TRICARE-authorized provider.
- Supervising authorized providers who employ NPs may bill as noted for the PA, or the NP may bill on their own behalf and use their NP provider number for procedures or services they perform.
- No payment may be made for an assistant surgeon when co-surgeons are reimbursed. Refer to the **TRM**, Chapter 1.

Providers should use the modifier that best describes the assistant surgeon services provided in Column 24D on the 1500 claim form:

- Modifier 80 indicates the assistant surgeon provided services in a facility without a teaching program.
- Modifier 81 is used for "Minimum Assistant Surgeon" when the services are only required for a short period during the procedure.
- Modifier 82 is used by the assistant surgeon when a qualified resident surgeon is not available.

**Note:** Modifiers 80 and 81 are applicable modifiers to use; however, they most likely will experience a wait for medical review to validate the medical necessity for surgical assistance and possibly result in a request for medical records. During the review process, the claim also will be reviewed to validate that the facility has (or does not have) residents and interns on staff (for example, small community hospital).

## Banked Donor Milk

Reimbursement for banked donor milk will be the lesser of billed charges, negotiated rates or the CMS' banked donor milk fee schedule. Reimbursement rates can be viewed at **www.health.mil**. Reimbursement includes the processing, storage and distribution of banked donor milk (Healthcare Common Procedure Coding System [HCPCS] code T2101). Charges for shipping or other services are not separately payable.

The prescription from the treating provider must be included when submitting claims for banked donor milk. This prescription must include the quantity, frequency and documentation that the beneficiary meets the medical needs for coverage. A certificate of medical necessity is not required. The claim must include documentation or verification that the banked donor milk provided was obtained from a milk bank accredited through the Human Milk Banking Association of North America. In lieu of separate clinical documentation, the treating provider can complete a **Banked Donor Milk Coverage Criteria Attestation** to be submitted with the claim.

## Breast Pumps and Supplies

Reimbursement for breast pumps and supplies will be the lesser of billed charges, negotiated rates or the CMS durable medical equipment (DME), prosthetics, orthotics, and supplies (DMEPOS) fee schedule. Reimbursement rates can be viewed at **www.health.mil** under the DMEPOS pricing.

Heavy duty, hospital-grade electric breast pumps may be covered as long as use is determined medically necessary and appropriate. When prescribing a hospital-grade breast pump,

supporting medical documentation is required. (Active duty service members [ADSM] require Health Net Federal Services, LLC's [HNFS] approval for hospital-grade breast pumps.) Hospital-grade breast pumps are customarily rented and submitted with the appropriate modifiers. Once the rental cost has reached the purchase price, the provider must consider the item purchased and may not continue to bill rental charges.

When the hospital-grade breast pump is no longer needed, a manual or standard electric breast pump may be covered with a new prescription. The prescription must include the type of breast pump needed and specify the number of weeks the beneficiary is pregnant or the age of the infant. A separate prescription is required for a supplemental nursing system, nipple shields (two sets) and additional breast pump supplies in excess of the allowances described under "***Breast Pumps and Supplies***" in the ***Medical Coverage*** section.

A certificate of medical necessity is not required. In lieu of creating a specific prescription form, the referring provider can complete our Breast Pump and Supplies Prescription Form. TRICARE covers standard shipping and handling charges for purchases made online.

# Diagnosis-Related Group Reimbursement

DRG reimbursement is a reimbursement system for inpatient charges from facilities. This system assigns payment levels to each DRG based on the average cost of treating all TRICARE beneficiaries in a given DRG. The TRICARE DRG-based payment system is modeled on the Medicare Inpatient Prospective Payment System (IPPS).

A grouper program classifies each case into the appropriate DRG.

The grouper used for the TRICARE DRG-based payment system is the same as the Medicare grouper with some modifications, such as neonate DRGs, age-specific conditions and mental health care DRGs. DRG payment includes New Technology Add-On Payments (NTAPs) in accordance with Medicare rules. TRICARE has adopted CMS' new technology add-on payment in addition to the DRG. See "***New Technology Add-On Payments***" in this section and refer to **TRM**, Chapter 6 for more details.

TRICARE uses the TRICARE Severity DRG payment system, which is modeled on the Medicare Severity DRG payment system.

**Note:** Final claims that are reimbursed under the TRICARE DRG-based payment system are priced using the rules, weights and rates in effect as of the date of discharge.

## Present on Admission Indicator

Inpatient acute care hospitals that are paid under the TRICARE DRG-based payment system are required to report a present on admission (POA) indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. POA is defined as present at the time the order for inpatient admission occurs.

Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered POA. Any hospital-acquired conditions, as identified by Medicare, will not be reimbursed. A list of hospital-acquired conditions can be found at **https://health.mil/rates**.

Any claim that does not report a valid POA indicator for each diagnosis on the claim will be denied. The five valid POA codes are described in Figure 8.1.

### POA Code Descriptions, Figure 8.1

| POA Code | Description |
|---|---|
| Y | Indicates that the condition was present on admission. |
| W | Affirms that the provider has determined based on data and clinical judgment it is not possible to document when the onset of the condition occurred. |
| N | Indicates that the condition was not present on admission. |
| U | Indicates the documentation is insufficient to determine if the condition was present at the time of admission. |
| 1 | Exempt from POA reporting. Exempt International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10) codes are available in the ICD-10 Official Coding Guidelines. |

**Note:** The POA field may be left blank for codes exempt from POA reporting.

The following hospitals are exempt from POA reporting for TRICARE:

- Critical access hospitals (CAH)
- Long-term care hospitals
- Cancer hospitals
- Children's inpatient hospitals
- Inpatient rehabilitation hospitals
- Psychiatric hospitals and psychiatric units
- U.S. Department of Veterans Affairs (VA) hospitals

## Diagnosis-Related Group Calculator

The DRG calculator is available at **www.health.mil/DRG**.

You can locate the indirect medical education (IDME) factor (for teaching hospitals only) and wage index information at **www.health.mil/DRG**. If a hospital is not listed, use "ZIP to Wage Index File" to obtain the wage index for that area by ZIP code.

## Hospital Value-Based Purchasing

TRICARE has aligned with Medicare's Hospital Value-Based Purchasing (HVBP) Program, which rewards acute care hospitals with incentive payments for the quality of care provided to beneficiaries, for hospitals subject to DRG-based payments. This program adjusts payments to hospitals under the IPPS based on the quality of care delivered. All hospitals that meet the classification criteria for payment under **Title 42, CFR, Part 412, Section 412.161**, are considered subject to HVBP under the TRICARE program.

Refer to the **TRM**, Chapter 1 for more details and exclusions under this reimbursement methodology.

# Capital and Direct Medical Education Cost Reimbursement

Facilities may request capital and direct medical educational cost reimbursement. Capital items (for example, property, structures and equipment) usually cost more than $500 and can depreciate under tax laws. Direct medical education is defined as formally organized or planned programs of study in which providers engage to enhance the quality of care at an institution.

Submit requests for reimbursement under capital and direct medical education costs to HNFS/PGBA on or before the last day of the twelfth month following the close of the hospital's cost-reporting period. The request shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. This applies to hospitals (except children's hospitals) subject to the TRICARE DRG-based system.

When submitting initial requests for capital and direct medical education reimbursement, the following should be included:

- Hospital name
- Hospital address
- Hospital Tax Identification Number
- Hospital Medicare Provider Number
- Time period covered (must correspond with the hospital's Medicare cost-reporting period)
- Total inpatient days provided to all beneficiaries in units subject to DRG-based payment
- Total TRICARE inpatient days, provided in "allowed" units, subject to DRG-based payment (excluding non-medically necessary inpatient days)
- Total inpatient days provided to ADSMs in units subject to DRG-based payment
- Total allowable capital costs (must correspond with the applicable pages from the Medicare cost report)
- Total allowable direct medical education costs (must correspond with the applicable pages from the Medicare cost report)
- Total full-time equivalents for residents and interns
- Total inpatient beds as of the end of the cost-reporting period
- Title of official signing the report
- Reporting date

The provider's office manager (or administrator) must include a statement certifying that any changes resulting from a Medicare audit will be reported to HNFS/PGBA within 30 days of the hospital's notification of the change. A failure to promptly submit an amended Medicare cost report is considered a misrepresentation of the cost report information and can be considered fraudulent.

# Drug Testing

TRICARE may cover the reporting of qualitative drug testing if the services were performed with either a blood or urine sample for patients with any of the following:

- Unreliable history
- Multiple drug ingestion
- Delirium, coma or other unexplained altered mental status
- Severe or unexplained cardiovascular instability
- Unexplained metabolic or respiratory acidosis
- Seizure with an undetermined history
- Medical condition(s) where drug toxicity may be a contributing factor
- Monitored compliance during active treatment for substance use

## Drug Testing Billing

- Dates of service on or after Jan. 1, 2017: CPT/HCPCS codes 80305–80307, G0480–G0483

# Durable Medical Equipment, Prosthetics, Orthotics and Supplies Pricing

DMEPOS prices are established by using Medicare fee schedules, reasonable charges, state prevailing rates, and average wholesale pricing (AWP). Most DME payments are based on a fee schedule established for each DMEPOS item. The services and/or supplies are coded using HCPCS Level II codes that begin with the letters:

- **A** (medical and surgical supplies)
- **B** (parenteral and enteral therapy)
- **E** (DME)
- **K** (temporary codes)
- **L** (orthotics and prosthetic procedures)
- **V** (vision services)

Reimbursement rates shall be based on Medicare's DMEPOS and PEN fee schedule amount.

If there is no Medicare rate, the contractor shall reimburse the durable equipment or DMEPOS item or service using TRICARE's DMEPOS fee schedule rates.

Inclusion or exclusion of a fee schedule amount for an item or service does not imply TRICARE coverage or non-coverage. Parenteral and enteral nutrition items and services and fees are also included with the DMEPOS schedule. DMEPOS pricing information is available at **https://health.mil/rates.** DME pre-authorization requirements are listed at **www.tricare-west.com**.

### Durable Medical Equipment Upgrades

The following billing guidelines must be followed for upgraded DME items.

When a beneficiary prefers to upgrade a prescribed DME item that otherwise meets TRICARE requirements, the beneficiary is responsible for the costs that exceed the standard equipment's allowed amount. The claim must be submitted with a GA modifier for the line item covered by the beneficiary and a GK modifier for the line item covered by TRICARE.

TRICARE network providers may collect payment for the non-covered upgrade or item from the beneficiary only when a **Request for Non-Covered Services** form is completed and submitted with the claim. Without this form, network providers may not bill the beneficiary, per TRICARE's hold harmless policy.

DME with upgraded features may be covered by TRICARE if the prescription specifically states the medical necessity.

Examples of upgraded features include wheels on walkers, power features for beds and wheelchairs, features that make use of an item easier for a caregiver or features that allow the beneficiary to use an item for more than general everyday use (such as use on off-pavement terrain).

## End Stage Renal (ESRD) Pricing

TRICARE reimburses freestanding ESRDs rendering covered hemodialysis and peritoneal dialysis services for the treatment of ESRD and acute kidney injury (AKI). This is dependent on the length of treatment and applies to dialysis treatments rendered by a freestanding ESRD facility, either in the clinic setting or in the home. Refer to **TRM**, Chapter 18, Section 1 for more information.

Reimbursement is based on a single, flat, per-session fee that is wage adjusted, which covers:

- Institutional charges, such as:
  - Charges for facility use
  - Use of treatment rooms
  - General nursing services (to include the services of technicians, nurses, and other staff involved in establishing, monitoring, or discontinuing the dialysis session)
- Laboratory services related to a dialysis session
- Pharmaceuticals and supplies related to a dialysis session
- Dialysis training (CPT codes 90989 and 90993)

The **dialysis training add-on payment** cannot be applied to treatment days 1-120. Refer to the CMS **ESRD PPS Consolidated Billing** page to identify services and supplies included in the per-session rate that are not eligible for separate payment.

Refer to **TRM**, Chapter 18, Section 1, paragraph 3.3. for per-session rate details.

## Health Professional Shortage Areas Bonus Payments

Network and non-network physicians (MDs, DOs), podiatrists, oral surgeons, and optometrists who qualify for Medicare bonus payments in Health Professional Shortage Areas (HPSAs) may be eligible for a 10% bonus payment for claims submitted to TRICARE. The only mental health care providers eligible for HPSA bonuses include MDs and DOs. Non-physicians (for example, PhDs, social workers, counselors, certified psychiatric nurse specialists, and marriage and family therapists) are not eligible.

Providers can determine if they are in an HPSA by accessing the U.S. Department of Health and Human Services, Health Resources and Services Administration's HPSA Find tool. The CMS has HPSA designations along with bonus payment information at **www.cms.gov**.

**Note:** The bonus payment is based on the ZIP code of the location where the service is actually performed (which must be in an HPSA), rather than the ZIP code of the billing office or other location.

### How Bonus Payments Are Calculated

For providers who are eligible and located in an HPSA, PGBA will calculate a quarterly 10% bonus payment from the total paid amount for TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Select, TRICARE Reserve Select (TRS), and Supplemental Health Care Program (SHCP) claims, and the amount paid by the government on other health insurance (OHI) claims. Please keep in mind the following:

- The AQ modifier is not required except in those instances where ZIP codes do not fall entirely within a full county HPSA bonus area. (In those instances and for CPT codes with multiple modifiers, place the AQ modifier last.)
- There are no retroactive payments, adjustments or appeals for obtaining a bonus payment.
- When calculating bonus payment for services that contain both a professional and technical component, only the professional component will be used.

## Home Health Agency Pricing

The TRICARE benefit for home health care services closely follows Medicare's Home Health Agency (HHA) Prospective Payment System (HHA-PPS). TRICARE has adopted Medicare's **Home Health Patient-Driven Groupings Model (PDGM)**, which is based on 30-day periods of care and does not use therapy thresholds to determine payments. Refer to **TRM**, Chapter 12, Section 9.

Authorizations for home health services, Outcome and Assessment Information Set (OASIS) assessments and updates to patient care plans remain on a 60-day basis. To receive private duty nursing or additional nursing services/shift nursing, the TRICARE beneficiary may be enrolled in an alternative DHA-approved special program, Extended Care Health Option (ECHO) Home Health Care (EHHC), and a case manager must manage the beneficiary's progress.

- **For pediatric (under age 18) or pregnant beneficiaries,** Medicare-certified home health agencies are required to conduct abbreviated OASIS assessments. This requires the manual completion and scoring of a Home Health Resources Group (HHRG) worksheet to generate a Health Insurance Prospective Payment System (HIPPS) code. The abbreviated 23-item assessment (as opposed to the full 79-item comprehensive assessment) provides the minimal amount of data required to generate the HIPPS code, a required element on home health claims (see below).
  - If there is not a Medicare-certified HHA available, HNFS may authorize skilled therapy, social work or skilled nursing home health services to a non-Medicare certified, but state-licensed agency that is under a Corporate Services Provider participation agreement. In this instance, CHAMPUS Maximum Allowable Charge (CMAC) reimbursement would be allowed and OASIS assessments not required.
- **For non-pregnant adults (18 years of age or greater)** receiving services from Medicare-certified home health agencies, TRICARE only allows for HHA-PDGM reimbursement. CMAC does not apply, even for providers who have received such reimbursement in the past.

### Low Utilization Payment Adjustment

Medicare-certified HHAs providing fewer than the threshold of visits (Low Utilization Payment Adjustment [LUPA] thresholds ranging from two to six visits) specified for the period's HHRG will be paid a standardized per-visit payment instead of a payment for a 30-day period of care.

The HIPPS code from the OASIS is needed to determine if the period of care meets the LUPA threshold.

- For patients under the age of 18 the OASIS collection is not required by Medicare, but completion of the abbreviated OASIS is required to generate the HIPPS code.
- PDGM LUPA thresholds are available under the applicable calendar year (CY) home health final rule.

### Episodes/Periods of Care

The CMS Notice of Admission (NOA) is not required in TRICARE. Pre-authorization will be used to establish the period of care. The unit of payment is based on the CY national, standardized 30-day payment amount.

Medicare updates HHA-PPS rates annually on a CY basis.

### Requests for Anticipated Payments (RAPS)/ Notice of Admission (NOA)

Submission of RAPs and NOAs is not required by TRICARE.

### Tips for a filing a claim

- Ensure pre-authorization approval is on file for dates of service that cover the HHA POC.
- The bill type in FL 4 always must be 329 and is to be submitted for each 30-day POC.
- List each actual service performed with the appropriate revenue code on the claim form lines.
- If the LUPA threshold is met, the period of care is reimbursed at the full 30-day national standard payment amount. If the LUPA threshold is not met, the period of care is reimbursed at the CY per-visit payment amount. Providers whose home health care claims were previously denied due to incomplete or missing information may resubmit corrected claims to HNFS using these billing guidelines.
- A Treatment Authorization Code (TAC) is not required.

### Extended Care Health Option

ECHO provides supplemental services to active duty family members (ADFMs) beyond what is offered through the basic TRICARE program.

*The above guidance does not apply to home health care services provided to ADFMs under the EHHC benefit.*

The EHHC benefit provides medically necessary skilled services or respite care to ECHO beneficiaries who are homebound and generally require more than 28 to 35 hours per week of home health services. Reimbursement for services covered under EHHC is based on the CMAC.

### Exceptions

Beneficiaries enrolled in the Custodial Care Transition Program (CCTP) are exempt from the new claim filing rules and providers treating them may continue fee-for-service billing. For details about beneficiaries grandfathered under the CCTP, refer to **TRICARE Policy Manual (TPM)**, Chapter 8.

## Home Infusion Drug Pricing

Home infusion drugs are those drugs (including chemotherapy drugs) that cannot be taken orally and are administered in the home by other means: intramuscularly, subcutaneously, intravenously, or infused through a piece of durable medical equipment (DME). DME verification is not required.

- Home infusion drugs (except those infused through DME), that are not available under TRICARE's pharmacy benefit are priced at the lesser of billed charges or 95 percent of the average wholesale price (AWP).
- Drugs (including home infusion drugs) infused through DME are priced at the Medicare Average Sale Price (ASP) plus 6%. The equipment must meet TRICARE's definition of DME **TPM**, Chapter 8, Section 2.1).

Home infusion drugs must be billed using an appropriate J, Q or S code along with a specific National Drug Code (NDC) for pricing.

Pre-authorization is required for all beneficiaries except those with other health insurance (OHI). The pre-authorization must be received before the initiation of the therapy to ensure medications are received from the correct TRICARE source

and any required nursing visits are pre-approved. Services rendered without pre-authorization may be ruled as non-covered benefits or may result in a payment penalty. When the provider initially certifies self or caretaker infusion, or injection is medically appropriate for either homebound or non-homebound beneficiaries, the beneficiary must receive education from a home health agency.

Nursing visits will be authorized by HNFS based on the type of services, homebound status of the beneficiary and classification of home health nursing provider. Homebound status for a beneficiary is determined by the provider.

The type of medication and length of administration will determine whether the home infusion/injection medication will be paid under the medical benefit or through the TRICARE pharmacy benefit.

Claims for home infusion will be identified by the place of service and the CMS HCPCS National Level II Medicare codes along with the specific NDC number of the administered drug.

# Hospice Pricing

Hospice programs are not eligible for TRICARE reimbursement unless they enter into an agreement with TRICARE. National Medicare hospice rates will be used for reimbursement of each of the following levels of care provided by, or under arrangement with, a Medicare-approved hospice program:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care

The national Medicare payment rates are designed to reimburse the hospice for the costs of all covered services related to treating the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice. The only amounts that will be allowed outside of the locally adjusted national payment rates and not considered hospice services will be for direct patient care services rendered by an independent attending physician.

When billing, hospices should keep in mind the following:

- Bill for physician charges/services (physicians under contract with the hospice program) on a UB-04 using revenue code 657 and the appropriate CPT codes.
- Payments for hospice-based physician services will be paid at 100% of the TRICARE-allowable charge and will be subject to the hospice cap amount (calculated into the total hospice payments made during the cap period).
- Bill independent attending physician services or patient-care services rendered by a physician not under contract with or employed by the hospice on a 1500 claim form using the appropriate CPT codes. These services will be subject to standard TRICARE reimbursement and cost-sharing/deductible provisions and will not be included in the cap amount calculations.

The hospice will be reimbursed for the amount applicable to the type and intensity of the services furnished to the beneficiary on a particular day. Each level of care will be paid at the same rate, except for continuous home care, which will be reimbursed based on the number of hours of continuous care furnished to the beneficiary on a given day. Reimbursement may be extended for routine and continuous hospice care provided to beneficiaries residing in a nursing home facility, that is, physician, nurse, social worker and home health aide visits to patients requiring palliative care for a terminal illness. TRICARE will not pay for the room and board charges of the nursing home.

**Note:** Continuous home care must be equal to or greater than eight hours per day, midnight to midnight, with at least 50% of care provided by licensed practical nursing or registered nursing staff. The rates will be adjusted for regional differences using appropriate Medicare area wage indexes.

# Long-Term Care Hospitals/ Inpatient Rehabilitation Facilities

Long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs) use CMS prospective payment system (PPS). Previously, reimbursement was based on TRICARE's lesser of cost or billed charges principle.

- **LTCHs** – Certified as acute care hospitals (ACHs), but focus on patients who, on average, stay more than 25 days.
- **IRFs** – Freestanding rehabilitation hospitals and rehabilitation units in ACHs that provide intensive rehabilitation programs. Patients who are admitted must be able to tolerate three hours of intense rehabilitation services per day.

## Long-Term Care Hospitals

LTCH admissions are reimbursed as follows:

- **Standard LTCH PPS payment rate:** To receive the standard LTCH PPS rate, the LTCH admission must occur within one day of a hospital discharge, which includes discharges from military or Department of Veterans Affairs (VA) hospitals.
- **Site-neutral LTCH PPS payment rate:** This lower reimbursement rate is for patients who do not use prolonged mechanical ventilation during their LTCH stay or who did not spend three or more days in the intensive care unit during their prior ACH stay, and for patients with a psychiatric or rehabilitation principal diagnosis.

Medicare posts updated rates to **www.cms.gov** in August each year for the fiscal year (Oct. 1) update.

## Inpatient Rehabilitation Facilities

Payment for IRFs is on a per discharge basis, with rates based on such factors as patient-case mix, rehabilitation impairment categories and tiered case-mix groups. Rates may be adjusted based on the length of stay, geographic area and demographic group. To be paid under the IRF PPS, facilities must meet requirements set forth in **Title 42, CFR, Part 412** and complete a Patient Assessment Instrument (PAI) in addition to supplying

the physician order for patient admission. Medicare provides IRF PAI software at **www.cms.gov**. Federal rates are updated annually.

ACHs rendering IRF services must meet *Subpart B of* **CMS Title 42, CFR, Part 412** requirements for classification as an IRF in order to be reimbursed under the IRF PPS.

Submission of claim must be either Healthcare Insurance Portability and Accountability Act (HIPAA)-compliant electronic claim or paper claim (UB-04) with the following codes:

- Bill Type 11X
- Revenue Code 0024

### Exclusions

The following are excluded:

- Hospitals with a waiver exempting them from Medicare's Inpatient Prospective Payment System (IPPS) or the TRICARE diagnosis-related group (DRG)-based payment system
- Children's and VA hospitals
- Costs of physician services or other professional services
- Custodial or domiciliary care, even if rendered in an otherwise authorized LTCH

## Modifiers

Industry-standard modifiers often are used with procedure codes to clarify the circumstances under which medical services were performed. Modifiers allow the reporting physician to indicate that a service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers may be used by the provider to indicate one of the following:

- A service or procedure has a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure was provided more than once.
- Unusual events occurred during the service.
- A procedure was terminated prior to completion. Providers should use applicable modifiers that fit the description of the service and the claim will be processed accordingly
  - CPT® and HCPCS publications contain lists of modifiers available for describing services.

## 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. TRICARE adopted the CMS NTAPs reimbursement methodology for new services/technology not yet in the DRG, under the hospital IPPS. CMS evaluates new technologies that may raise the cost of care beyond the base DRG payment – taking into account newness, clinical benefit and cost – to determine which qualify for an NTAP.

TRICARE's adoption of NTAPs applies to hospital discharges on or after Jan. 1, 2020. Pediatric-specific NTAPs apply to hospital discharges on or after July 1, 2022. For TRICARE-specific NTAP requirements, refer to **TRM**, Chapter 6, Section 11.

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

- 100% of the average cost of the technology, or
- 100% of the total covered costs that exceed the Medicare Severity (MS)-DRG payment.

For inpatient hospital claims, non-pediatric 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.

Per law and regulation, NTAPs are allowed until they are incorporated into the DRG, which can take between two and three years. Find the current list of NTAPs and reimbursement rules at **www.cms.gov.** CMS updates maximum NTAP payment amounts annually.

### TRICARE-Designated NTAPs

DHA establishes TRICARE-designated NTAPs for covered services and supplies for which CMS has not established an NTAP adjustment for DRGs. Technology manufacturers may submit a TRICARE NTAP application to request a new TRICARE-designated NTAP. Applications must be received by July 8 of the preceding fiscal year for which the TRICARE-specific NTAP is to be considered. Find the application and submission instructions on our **Forms** page.

### New COVID-19 Treatments Add-on Payments (NCTAP)

For dates of service between Jan. 12, 2023, through May 11, 2023, TRICARE adopted the Centers for Medicare & Medicaid Services' (CMS) NCTAP for DRGs under CMS' Inpatient Prospective Payment System. Hospitals can request NCTAPs for eligible inpatient TRICARE beneficiaries who received FDA-approved COVID-19 treatments during this period. We can accept NCTAP review requests via our customer service line, through our *"Ask Us"* secure tool (log in required), or by postal mail at:

Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE
TRICARE West – Claims Correspondence,
PO Box 202100
Florence, SC 29502-2100.

To be eligible for an NCTAP, cases must have met all three of the following criteria:

- An FDA-approved drug or biological product authorized by CMS to treat COVID-19 was used
- Dates of service(s) were between Jan. 12, 2023, through May 11, 2023
- Operating costs of the case exceeded the full DRG payment, including the DRG adjustment and any other adjustments under Section 3710 of the CARES Act

For more information on NCTAPs, refer to **TRM**, Chapter 1, Section 42 or CMS' **NCTAP** page.

# Outpatient Prospective Payment System

The outpatient prospective payment system (OPPS) is the payment methodology used to reimburse for hospital outpatient services.

TRICARE's OPPS is mandatory for both network and non-network providers and applies to all hospitals participating in the Medicare program, with some exceptions. TRICARE's OPPS also applies to hospital-based partial hospitalization programs (PHPs) subject to TRICARE's pre-authorization requirements and hospitals (or distinct parts thereof) that are excluded from the inpatient diagnosis-related group (DRG)-based payment system to the extent the hospital (or distinct part thereof) furnishes outpatient services.

**Note:** Effective Oct. 1, 2023, cancer and children's hospitals are subject to OPPS. See our **Cancer and Children's Hospital Billing** page.

Several organizations, as defined by TRICARE policy, are exempt from OPPS:

- CAHs
- Certain hospitals (for example, Maryland) that qualify for payment under state cost containment waivers
- Hospitals located outside one of the 50 United States, Washington, D.C. and Puerto Rico
- Indian Health Service hospitals that provide outpatient services
- Specialty care providers, including:
  - Community mental health care centers
  - Comprehensive outpatient rehabilitation facilities
- Department of Veterans Affairs (VA) hospitals
- Freestanding ambulatory surgery centers (ASCs)
- Freestanding birthing centers
- Freestanding end-stage renal disease facilities
- freestanding PHPs and substance use disorder rehabilitation facilities (SUDRFs)
- Home health agencies (HHAs)
- Hospice programs
- Other corporate services providers (for example, freestanding cardiac catheterization and sleep disorder diagnostic centers)
- Skilled nursing facilities
- Residential treatment centers (RTCs)

For more information on OPPS implementation, refer to the **TRM**, Chapter 13 and visit **https://health.mil/rates**.

## Inpatient-Only Services

As with Medicare, certain procedures are only payable by TRICARE when performed in an inpatient setting. TRICARE designates these as inpatient only services, and they are not covered when performed in an outpatient or ambulatory setting. Associated services such as facility, anesthesiologist and other procedures performed also are not covered. View the list of inpatient only procedures at **https://health.mil/rates**.

**Note:** The TRICARE Inpatient Only List does not apply to hospital outpatient departments in states with CMS waivers. In these states, TRICARE-authorized hospitals may receive reimbursement for TRICARE-designated inpatient only services performed in an outpatient setting, including associated services such as facility, anesthesiologist and other procedures. Pre-authorization may be required.

## Outpatient Lab Tests

It is optional for OPPS hospitals to seek separate payment under the clinical laboratory fee schedule for a given outpatient lab test. Hospitals are responsible for using the appropriate coding and determining when separate billing is warranted.

## Outpatient Observation Stays

Outpatient observation stays are reimbursed per the TRICARE OPPS methodology. A minimum of eight hours or more of observation is required for consideration of payment.

For details on how the TRICARE OPPS affects outpatient observation stays, refer to the **TRM**, Chapter 13. Outpatient observation stays are also reimbursed to non-OPPS facilities for up to 48 hours.

If after 48 hours it becomes apparent the patient must continue as an inpatient, authorization for the inpatient admission must be obtained and medical necessity provided. For details on non-OPPS outpatient observation stays, refer to the **TPM**, Chapter 2. HNFS requires notification of all inpatient facility admission and discharge dates by the next business day following the admission and discharge. HNFS will conduct continued stay reviews for services that require pre-authorization.

## Partial Hospitalization Program Claims

TRICARE reimburses outpatient claims for PHP services for hospital-based and PHPs (mental health and SUDRFs) subject to TRICARE pre-authorization requirements.

TRICARE reimburses, under OPPS, a national per diem ambulatory payment classification (APC) payment. The OPPS is mandatory for both network and non-network providers. TRICARE follows Medicare's reimbursement methodology, which uses two separate APC payment rates to reimburse hospital-based OPPS PHP claims. Visit **https://health.mil/rates** for current APCs and rates.

When billing hospital-based PHP care under OPPS:

1. Report PHP services on a UB-04 claim form
2. List the appropriate HCPCS and revenue codes separately for each service date
3. The bill type must be 013X
4. Condition code 41 must be present on the claim
5. A mental health primary diagnosis is needed
6. A minimum of three units of service per day

For more detail about PHP services under TRICARE OPPS refer to the **TRM**, Chapter 13.

TRICARE also continues to reimburse freestanding PHP (non-OPPS) claims. Payment continues to be under the current TRICARE regional per diem rate schedule. Bill PHP care on UB-04 forms with a minimum of three units of service per day and use the following codes:

*Revenue code 0912*

- **Mental health care PHP** – All-inclusive per diem payment of three to five hours (half day); or
- **Substance use disorder (SUD) dependency PHP** – All-inclusive per diem payment of three to five hours (half day)

*Revenue code 0913*

- **Mental health partial hospitalization** – all-inclusive per diem payment of six or more hours (full day); or
- Substance use disorder partial hospitalization – all-inclusive per diem payment of six or more hours (full day)

**Note:** Revenue codes must be billed separately for each date of service. For more information about PHP services in a non-OPPS facility, refer to the **TPM**, Chapter 7.

*For OPPS and non-OPPS PHP programs:*

- **Services that may be billed separately** – TRICARE states physicians, clinical psychologists, clinical nurse specialists, nurse practitioners, and physician assistants can bill separately for their professional services.
- **Services included in the PHP payment** – TRICARE's reimbursement includes the provider's overhead costs, support staff and those services furnished by clinical social workers, occupational therapists and alcohol and addiction counselors.

# Skilled Nursing Facility Pricing

CMS utilizes a case-mix classification model called the Patient-Driven Payment Model (PDPM) for skilled nursing facility (SNF) pricing. Under PDPM, there are six payment components. Five are case-mix adjusted to allow for variances in diagnoses, severity of illness and other variables associated with the probability of improvement with treatment.

- **Physical therapy (PT)** – Includes a variable per diem factor
- **Occupational therapy (OT)** – Includes a variable per diem factor
- **Speech language pathology (SLP)**
- **Nursing**
- **Non-therapy ancillary (NTA) services** – Includes a variable per diem factor

The sixth payment component is a non-case–mix adjusted component to cover utilization of SNF resources that do not vary according to patient characteristics.

The payment for each component is calculated as:

**Patient's case-mix group X wage-adjusted component base payment rate X day in variable per diem adjustment schedule, when applicable**.

The payments for each component are then added together along with the non–case-mix component payment rate. This creates the patient's total SNF prospective payment system (PPS) per diem rate under the PDPM:

**PT + OT + SLP + Nursing + NTA + Non–Case-Mix = SNF PPS per diem rate**.

Visit **www.cms.gov** for PDPM resources.

## Interrupted stay billing

TRICARE has adopted Medicare's interrupted stay policy for SNF admissions. An interrupted SNF stay is one in where a patient is discharged from an SNF and subsequently readmitted to the same SNF within three days.

The three-day interruption or leave of absence window begins on the first non-covered day following the SNF stay and ends at 11:59 p.m. on the third consecutive non-covered day. Follow these Medicare guidelines when billing:

- Use revenue code 018x and occurrence span code 74,
- Indicate the interruption "from" and "through" dates, and
- Put the number of non-covered days as units. The interrupted stay policy does not apply if:
  - The patient is readmitted to the same SNF outside the three-day interruption window.
  - The patient is admitted to a different SNF (regardless of the length of time between stays).

SNF admissions require pre-authorization when TRICARE is the primary payer.

SNFs' admissions for children under age 10 and critical access hospital (CAH) swing beds are exempt from SNF PPS and reimbursed based on DRG or contracted rates.

For more information about SNF PPS, refer to the **TRM**, Chapter 8.

# Sole Community Hospitals

Sole community hospitals (SCHs) are geographically isolated hospitals serving a population relying on that hospital for most inpatient care. To align TRICARE reimbursements with Medicare, in-network inpatient care provided in an SCH shall be paid under the primary and secondary methodology described in the **TRM**, Chapter 14. For outpatient SCH reimbursement, refer to **TRM** Chapter 12. TRICARE-authorized hospital providers must immediately inform HNFS of any change in CMS' hospital classification. Notification by the hospital must occur if the provider changes from a short-term acute care hospital (ACH) classification, critical access hospital (CAH) classification or SCH classification to any other of the three noted classifications. This notification allows HNFS to properly reimburse hospitals for TRICARE-covered services. See "***Hospital and Facility Billing***" in the ***Claims Processing and Billing Information*** section of this handbook.

# Surgeon's Services for Multiple Surgeries

Multiple surgical procedures have specific reimbursement requirements. When multiple surgical procedures subject to discounting are performed, the primary procedure (such as, the procedure subject to discounting with the highest TRICARE-allowable charge) will be paid at 100% of the contracted rate. Any additional covered procedures performed during the same session will be allowed at 50% of the contracted rate.

An incidental surgical procedure is one that is performed at the same time as a more complex primary surgical procedure. However, the incidental procedure requires fewer additional physician resources and/or is clinically integral to the performance of the primary procedure. Therefore, an incidental procedure will not be reimbursed unless it is required for surgical management of multiple traumas or if it involves a major body system different from the primary surgical service.

# Updates to TRICARE Rates and Weights

Reimbursement rates and methodologies are subject to change per Department of Defense (DOD) guidelines. TRICARE rates are subject to change on at least an annual basis, when the DOD adjusts TRICARE reimbursement rates to mirror Medicare's levels. Rate changes are usually effective on the dates listed in Figure 8.2. Updated rates and weights are available at **https://health.mil/rates**.

TRICARE Rate Updates Schedule Figure 8.2

This list is not all-inclusive.

**TRICARE Rate Updates Schedule Figure 8.2**

| Update Frequency | Description |
|---|---|
| **Variable at DHA's discretion** | • CMAC – may be adjusted quarterly<br>• Anesthesia<br>• Injectables<br>• Immunizations |
| **January 1** | • Ambulance fee schedule<br>• Sole community hospital<br>• Breastfeeding supplies |
| **October 1** | • RTCs<br>• PHPs<br>• IOPs<br>• Opioid treatment programs<br>• Mental health care per diem<br>• SNF prospective payment system PPS – may be adjusted quarterly<br>• Hospice<br>• LTCH IRF PPS<br>• Inpatient hospital copayments and cost-shares |
| **November 1** | Ambulatory surgery grouper |
| **Quarterly** (January, April, July, October) | • DMEPOS<br>• HHA-PPS<br>• OPPS |
| **December 1** | CAHs |

# Provider Resources

## Acronyms and Abbreviations

| | |
|---|---|
| **ABA** | Applied behavior analysis |
| **ABAT®** | Applied Behavior Analysis Technician® |
| **ABPM** | Ambulatory blood pressure monitoring |
| **ACD** | Autism Care Demonstration |
| **ACH** | Acute care hospital |
| **ACSP** | Autism Cre Demonstration Corporate Services Provider |
| **ADDP** | Active Duty Dental Program |
| **ADFM** | Active duty family member |
| **ADSM** | Active duty service member |
| **AHRQ** | U.S. Department of Health and Human Services Agency for Healthcare Research and Quality |
| **ALS** | Advanced Life Support |
| **APC** | Ambulatory payment classification |
| **ASC** | Ambulatory surgery center |
| **ASP** | Average Sale Price |
| **ASN** | Autism Services Navigator |
| **AWP** | Average wholesale price |
| **BACB®** | Behavior Analyst Certification Board, Inc.® |
| **BCaBA®** | Board Certified Assistant Behavior Analyst® |
| **BCAC** | Beneficiary Counseling and Assistance Coordinator |
| **BCBA®** | Board Certified Behavior Analyst® |
| **BCBA-D®** | Board Certified Behavior Analyst – Doctoral® |
| **BCAT** | Board Certified Autism Technician |
| **BLS** | Basic life support |
| **CAC** | Common Access Card |
| **CAH** | Critical access hospital |
| **CARES** | Coronavirus Aid, Relief, and Economic Security Act |
| **CARF** | Council on Rehabilitation Facilities® |
| **CBSD** | Childbirth and Breastfeeding Support Demonstration |
| **CHAMPUS** | Civilian Health and Medical Program of the Uniformed Services (now called TRICARE) |
| **CHAMPVA** | Civilian Health and Medical Program of the Department of Veterans Affairs (Veterans Affairs health care program for patients) |
| **CCTP** | Custodial Care Transition Program |
| **CDC** | Centers for Disease Control and Prevention |
| **CHCBP** | Continued Health Care Benefit Program |
| **CLR** | Clear and legible report |
| **CMAC** | CHAMPUS maximum allowable charge |
| **CMN** | Certificate of Medical Necessity |
| **CMS** | Centers for Medicare & Medicaid Services |
| **CoA** | Council on Accreditation |
| **COB** | Coordination of benefits |
| **COVID-19** | Coronavirus disease 2019 |
| **CFR** | Code of Federal Regulations |
| **CPR** | Cardiopulmonary resuscitation |
| **CPT®** | Current Procedural Terminology<br>*CPT® is a registered trademark of the American Medical Association. All rights reserved.* |
| **CQM** | Clinical Quality Management |
| **C-section** | Caesarean section |
| **CY** | Calendar year |
| **DBN** | Department of Defense Benefits Number |
| **DCAO** | Debt Collection Assistance Officer |
| **DCN** | Document control number |
| **DEA** | U.S. Drug Enforcement Agency |
| **DEERS** | Defense Enrollment Eligibility Reporting System |
| **DHA** | Defense Health Agency |
| **DHA-GL** | Defense Health Agency-Great Lakes |

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|---|---|
| **DMAT** | Disaster Medical Assistance Team |
| **DME** | Durable medical equipment |
| **DMEPOS** | Durable medical equipment, prosthetics, orthotics, and supplies |
| **DNV** | Det Norske Veritas |
| **DO** | Doctor of osteopathic medicine |
| **DOD** | Department of Defense |
| **DRG** | Diagnosis-related group |
| **DTF** | Dental treatment facility |
| **ECHO** | Extended Care Health Option |
| **EDI** | Electronic data interchange |
| **EFMP** | Exceptional Family Member Program |
| **EFT** | Electronic funds transfer |
| **EHHC** | ECHO Home Health Care |
| **EIN** | Employee identification number |
| **EOB** | Explanation of benefits |
| **EPSDT** | Early and Periodic Screening, Diagnosis, and Treatment |
| **ERA** | Electronic remittance advice |
| **ERSA** | External resource sharing agreement |
| **ESRD** | End-stage renal disease |
| **FASC** | Freestanding ambulatory surgery center |
| **FDA** | U.S. Food and Drug Administration |
| **FECA** | Federal Employees Compensation Act |
| **FEDVIP** | Federal Employees Dental and Vision Insurance Program |
| **FFCRA** | Families First Coronavirus Response Act |
| **FIPS** | Federal Information Processing Standards |
| **HBA** | Health Benefits Advisor |
| **HCFA** | Health Care Financing Administration (now CMS) |
| **HCPCS** | Healthcare Common Procedure Coding System |
| **HEDIS** | Healthcare Effectiveness Data and Information Set |
| **HFAP** | Healthcare Facilities Accreditation Program |
| **HHA** | Home health agency |
| **HHA-PPS** | Home Health Agency – Prospective Payment System |
| **HHRG** | Home Health Resources Group |
| ***HIPAA*** | *Health Insurance Portability and Accountability Act of 1996* |
| **HIPPS** | Health Insurance Prospective Payment System |
| **HHVBP** | Home Health Value-Based Purchasing |
| **HMBANA** | Human Milk Banking Association of North America |
| **HNFS** | Health Net Federal Services, LLC |
| **HPSA** | Health Professional Shortage Area |
| **ICD-10/ ICD-10-CM** | International Classification of Diseases, Tenth Revision, Clinical Modification |
| **ID** | Identification |
| **IDES** | Integrated Disability Evaluation System |
| **IDME** | Indirect medical education |
| **IOP** | Intensive outpatient program |
| **IPPS** | Inpatient Prospective Payment System |
| **IRF** | Inpatient rehabilitation facility |
| **LABA** | Licensed assistant behavior analyst |
| **LCSW** | Licensed clinical social worker |
| **LDT** | Laboratory-developed test |
| **LOA** | Letter of attestation |
| **LOD** | Line of duty |
| **LPN** | Licensed practical nurse |
| **LTCH** | Long-term care hospital |
| **LUPA** | Low Utilization Payment Adjustment |
| **LVN** | Licensed vocational nurse |
| **MD** | Doctor of medicine |
| **MHS** | Military Health System |
| **MRI** | Magnetic resonance imaging |
| **NATO** | North Atlantic Treaty Organization |
| **NCI** | National Cancer Institute |
| **NCQA** | National Committee for Quality Assurance |
| **NDC** | National Drug Code |
| **NDMS** | National Disaster Medical System |
| **NOAA** | National Oceanic and Atmospheric Administration |
| **NOE** | Notification of eligibility |
| **NP** | Nurse practitioner |
| **NPES** | National Plan & Provider Enumeration System |
| **NPI** | National Provider Identifier |
| **NQMC** | National Quality Monitoring Contractor |
| **NTA** | Non-therapy ancillary |
| **NTAP** | New Technology Add-On Payment |
| **NUCC** | National Uniform Claim Committee |
| **OASIS** | Outcome and Assessment Information Set |
| **OB/GYN** | Obstetrics and gynecology |
| **OHI** | Other health insurance |
| **OPM** | U.S. Office of Personnel Management |
| **OPPS** | Outpatient Prospective Payment System |
| **OT** | Occupational therapy |
| **OTP** | Opioid treatment program |
| **PA** | Physician assistant |
| **PAI** | Patient Assessment Instrument |
| **PAR** | Payment adjustment report |

| | |
|---|---|
| **PARB** | Prior Authorization, Referral and Benefit Tool |
| **PCM** | Primary care manager |
| **PDGM** | Patient-Driven Groupings Model – home health |
| **PDPM** | Patient-Driven Payment Model – skilled nursing facility |
| **PDTS** | Pharmacy Data Transaction Service |
| **PE** | Prolonged exposure |
| **PEN** | Parenteral and enteral nutrition |
| **PGBA** | PGBA, LLC |
| **PHI** | Protected health information |
| **PHP** | Partial hospitalization program |
| **PHS** | U.S. Public Health Service |
| **PDMP** | Prescription Drug Monitoring Program |
| **PDPM** | Patient-Driven Payment Model |
| **PMP** | Prescription Monitoring Program |
| **POA** | Present on admission |
| **POC** | Point of contact |
| **POS** | Place of service |
| **PPO** | Preferred provider organization |
| **PPS** | Prospective payment system |
| **PQI** | Potential quality issue |
| **PRO** | Peer Review Organization |
| **PSA** | Prime service area |
| **PT** | Physical therapy |
| **PTSD** | Post traumatic stress disorder |
| **QASP-S®** | Qualified Autism Service Practitioner – Supervisor |
| **RAP** | Request for Anticipated Payment |
| **RBT®** | Registered Behavior Technician® |
| **RN** | Registered nurse |
| **ROFR** | Right of first refusal |
| **ROTC** | Reserve Officer Training Corps |
| **RTC** | Residential treatment center |
| **RUG** | Resource Utilization Group |
| **RVU** | Relative value unit |
| **SAMHSA** | Substance Abuse and Mental Health Services Administration |
| **SAS** | Specified Authorization Staff |
| **SCH** | Sole community hospital |
| **SHCP** | Supplemental Health Care Program |
| **SLP** | Speech-language pathology |
| **SMCM** | Specialty Medication Care Management |
| **SNF** | Skilled nursing facility |
| **SSN** | Social Security number |
| **SUD** | Substance use disorder |
| **SUDRF** | Substance use disorder rehabilitation facility |
| **SVA** | State vaccine program |
| **TAC** | Treatment authorization code |
| **TAMP** | Transitional Assistance Management Program |
| **TCSRC** | Transitional Care for Service-Related Conditions |
| **TDP** | TRICARE Dental Program |
| **TFL** | TRICARE For Life |
| **THP** | TRICARE Health Plan |
| **TIN** | Tax Identification Number |
| **TJC** | The Joint Commission |
| **TOM** | TRICARE Operations Manual |
| **TOP** | TRICARE Overseas-Prime |
| **TPL** | Third Party Liability |
| **TPM** | TRICARE Policy Manual |
| **TPR** | TRICARE Prime Remote |
| **TPRADFM** | TRICARE Prime Remote for Active Duty Family Member |
| **TPS** | Total Performance Score |
| **TQMC** | TRICARE Quality Monitoring Contract |
| **TRM** | TRICARE Reimbursement Manual |
| **TRR** | TRICARE Retired Reserve |
| **TRS** | TRICARE Reserve Select |
| **TSM** | TRICARE System Manual |
| **TYA** | TRICARE Young Adult |
| **UM** | Utilization Management |
| **USFHP** | US Family Health Plan |
| **VA** | Department of Veterans Affairs |
| **VAMC** | VA Medical Center |
| **WCS** | Warrior Care Support Program |
| **WPS** | Wisconsin Physicians Service – Military Veterans Health |

# Glossary of Terms

## Abuse

The improper or excessive use of program benefits, resources, or services by a provider or beneficiary. Abuse can be either intentional or unintentional and can occur when:

- Excessive or unnecessary services are used.
- Services are not appropriate for the beneficiary's condition.
- A beneficiary uses an expired or voided identification (ID) card.
- A more expensive treatment is rendered when a less expensive treatment would be as effective.
- A provider or beneficiary files false or incorrect claims.
- Billing or charging does not conform to TRICARE requirements.

## Accepting assignment

Accepting assignment refers to when a provider agrees to accept the TRICARE-allowable charge as payment in full. Network providers accept assignment on all claims and non-network providers may choose to accept assignment on a claim-by-claim basis.

## Allowable charge review

An allowable charge review is a method by which a provider may request a review of a claim he or she deems was paid at an inappropriate level.

## Appeals review

Method by which a non-network participating provider (that is, one who has accepted assignment) may request a review.

## Authorization

See ***pre-authorization***.

## Autism Services Navigators (ASNs)

Effective Oct. 1, 2021, Health Net Federal Services, LLC (HNFS) assigns ASNs to beneficiaries new to the Autism Care Demonstration (ACD) once enrollment criteria is met. ASNs serve as primary health care advocates, helping beneficiaries and their families navigate the benefits and resources available. ASNs are licensed professionals with clinical experience in pediatrics, behavioral health, mental health, and/or autism spectrum disorder. ASNs help identify individual support needs and assists in coordinating care.

## Balance billing

When a provider bills a beneficiary for the difference between billed charges and the TRICARE-allowable charge after TRICARE (and other health insurance) has paid everything it is going to pay. Providers are prohibited from balance billing.

## Beneficiary

A beneficiary is a person who is eligible for TRICARE benefits. Beneficiaries include active duty family members and retired service members and their families. Other beneficiary categories are listed in the ***TRICARE Eligibility*** section of this handbook.

## Beneficiary Counseling and Assistance Coordinators (BCACs)

Persons at military hospitals and clinics, and TRICARE Regional Offices, who are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining medical care through TRICARE. BCACs were previously known as Health Benefits Advisors, or HBAs. To locate a BCAC, visit **www.tricare.mil/bcacdcao**.

## CAQH

The CAQH Universal Provider Datasource (UPD) is a web-based database to gather timely, electronic, self-reported provider data for credentialing purposes.

## Care coordination

An approach to care management using proactive methods to optimize health outcomes and reduce risks of future complications over a single, short-term (two to six weeks) episode of care. Prospective and concurrent reviews are used to identify current and future beneficiary needs.

## Case management

A collaborative process normally associated with multiple episodes of health care intervention that assesses plans, implements, coordinates, monitors and evaluates options and services to meet a beneficiary's complex health needs. This is accomplished through communication and available resources that promote quality, cost-effective outcomes.

## Catastrophic cap

The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given **calendar year**. **Point-of-service** cost-shares and the **Point-of-service** deductible are not applied to the catastrophic cap.

## Centers for Medicare & Medicaid Services

The federal agency that oversees all aspects of health care claims filing for Medicare (formerly known as the Health Care Financing Administration).

## Certified provider

See ***TRICARE-authorized provider***.

## CHAMPUS Maximum Allowable Charge (CMAC)

The maximum amount TRICARE will cover for nationally established fees (that is, fees for professional services).

CMAC is the TRICARE CHAMPUS Allowable Charge for covered services when appropriately applied to services priced under CMAC.

## Childbirth and Breastfeeding Support Demonstration (CBSD)

Effective 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 eligible beneficiaries.

## Circumvention

A term used to describe inappropriate medical practices or actions that result in unnecessary multiple admissions of an individual.

## Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

The former health care program established to provide health care coverage for active duty family members and retirees and their family members. TRICARE was organized as a separate office under the Assistant Secretary of Defense and replaced CHAMPUS in 1994.

## Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

CHAMPVA is the federal health benefits program for family members of 100 percent totally and permanently disabled Veterans. To be eligible for CHAMPVA, the beneficiary cannot be eligible for TRICARE/CHAMPUS and he or she must be either the spouse or child of a Veteran who has been rated permanently and totally disabled for a service-connected disability by a VA regional office; the surviving spouse or child of a Veteran who died from a VA-rated service connected disability; the surviving spouse or child of a Veteran who was at the time of death rated permanently and totally disabled from a service connected disability or the surviving spouse or child of a military member who died in the line of duty, not due to misconduct (in most of these cases, these family members are eligible for TRICARE, not CHAMPVA). CHAMPVA is administered by the Department of Veterans Affairs (VA) and is not associated with the TRICARE program. For questions regarding CHAMPVA, call **1-800-733-8387** or email **hac.inq@va.gov**.

## ClaimsXten™

A customized, automated claims auditing software that verifies coding accuracy of professional claims.



## Claim form (1500 Health Insurance Claim Form)

The professional claim form used as of January 2014.

## Clear and legible report (CLR)/ consultation report

For care referred from a military hospital or clinic to a civilian network provider, network providers must provide consultation reports – also known as patient encounter reports, or CLRs. CLRs should include consultation and operative reports, notes regarding the episode of care and discharge summaries. They should be sent to the initiating provider within seven business days of the beneficiary's care. Visit our **Clear and Legible Reports** page for current information regarding submission guidelines for CLRs.

## Concurrent review

A review with the purpose of validating the appropriateness of the admission, level of care, medical necessity, and quality of care, as well as the information provided during earlier reviews that is performed during a beneficiary's inpatient admission. Additional functions performed include screening for case management and identification of discharge planning needs. The review may be conducted by telephone or on site. Concurrent reviews are generally performed when TRICARE is the primary payer. Concurrent reviews are referred for medical director review when they indicate that criteria are not met.

## Copayment

A fixed amount a TRICARE beneficiary pays for certain types of services. A copayment is often called a copay. Copayment amounts are available at **www.tricare-west.com**.

**Note:** Waiving beneficiary copayments, cost-shares or deductibles can mean TRICARE will refuse to pay the claim and may result in the removal of the provider from the network and suspension of authorized provider status under TRICARE.

## Corporate services provider

A class of TRICARE-authorized providers consisting of institutional-based or freestanding corporations and foundations that render professional ambulatory or in-home care and technical diagnostic procedures.

## Cost-share

The percentage of the TRICARE-allowable charges a beneficiary will pay under TRICARE Select, TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR). Cost-share amounts are available at **www.tricare-west.com**.

**Note:** Extended Care Health Option (ECHO) services also have cost-shares, regardless of the beneficiary's program option (including TRICARE Prime). Waiving beneficiary copayments, cost-shares or deductibles can mean TRICARE will refuse to pay the claim and may result in the removal of the provider from the network and suspension of authorized provider status under TRICARE.

## Covered services

The health care services, equipment and supplies that are covered under the TRICARE program.

## Credentialing

The process that evaluates and subsequently allows providers to participate in the TRICARE network. This includes a review of the provider's training, educational degrees, licensure, practice history, etc.

## Current Procedural Terminology (CPT)

A systematic listing and coding of procedures and services performed by physicians. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physician is accurately identified.

## Deductible

The annual amount a TRICARE Select, TRICARE Reserve Select or TRICARE Retired Reserve beneficiary must pay for covered outpatient benefits before TRICARE begins to share costs. TRICARE Prime and TRICARE Prime Remote beneficiaries do not have an annual deductible, unless they are utilizing their **point-of-service** option. Deductible amounts are available at **www.tricare-west.com**.

## Defense Enrollment Eligibility Reporting System (DEERS)

The DEERS database consists of uniformed services members (sponsors), family members, and others worldwide who, under law, are entitled to military benefits, including TRICARE. Beneficiaries are required to keep DEERS updated. Refer to the ***TRICARE Eligibility*** section for more information. The DEERS database is the official record system for TRICARE eligibility.

## Department of Defense Benefits Number (DBN)

The DBN is a unique identifying number on military identification (ID) cards of those eligible to receive military benefits. The DBN replaces Social Security numbers (SSNs) on military ID cards. The DBN is an 11-digit number that relates to TRICARE benefit eligibility. The DBN should be used for medical care and claims, as well as other military benefits such as the Commissary. This number is located on the back of the ID card, at the top and is different than the 10-digit DOD ID number also contained on the card. Visit the HNFS **Using the Correct Military Identification Card Number** page for more information.

## Designated provider (DP)

Under the US Family Health Plan (USFHP), DPs, formerly known as uniformed service treatment facilities, are selected civilian medical facilities around the U.S. assigned to provide care to eligible USFHP beneficiaries – including those who are age 65 and older – who live within the DP area. At these DPs, the USFHP provides TRICARE Prime benefits and cost-shares for eligible persons who enroll in USFHP, including those who are Medicare eligible.

## Diagnosis-related group (DRG)

A reimbursement methodology used for inpatient care in some hospitals.

## Discharge planning

A process that assesses requirements and the coordination of care for a beneficiary's timely discharge from an acute inpatient setting to a post-care environment without need for additional military hospital or clinic or network provider assistance.

## Disease management

A prospective, disease-specific approach to improving health care outcomes by providing education to beneficiaries through non-physician practitioners who specialize in targeted diseases.

## Explanation of benefits (EOB)

A statement showing that a claim was processed and indicates the amount paid to the provider.

## Extended Care Health Option (ECHO)

The ECHO program is a supplemental program to the TRICARE basic program. It provides eligible active duty family members with additional financial resources for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the beneficiary's qualifying condition. Qualifying conditions may include moderate or severe mental retardation, a serious physical disability or an extraordinary physical or psychological condition such that the beneficiary is homebound.

## Fraud

An instance in which the provider deliberately deceives the regional contractor to obtain payment for services not actually delivered or received, or when a beneficiary deliberately deceives the regional contractor to claim program eligibility.

## Grievance

A grievance is a written complaint or concern from a TRICARE beneficiary or a provider on a non-appealable issue. Grievances address issues of perceived failure by any member of the health care delivery team – including TRICARE military providers, HNFS, or HNFS subcontractor personnel – to provide appropriate and timely health care services, access to care, quality of care, or level of care or service to which the beneficiary or provider feels they are entitled.

## Healthcare Common Procedure Coding System (HCPCS)

A set of codes used by Medicare that describes services and procedures. The HCPCS codes include Current Procedural Terminology (CPT) codes for services not included in the normal CPT code list, such as durable medical equipment and ambulance service. While HCPCS is nationally defined, there is a provision for local use of certain codes.

## *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*

HIPAA is a federal regulation implemented to improve portability and continuity of health insurance coverage in group and individual markets; safeguard protected health information, including regulation of electronic health information; combat waste, fraud and abuse in health insurance and health care delivery; promote use of medical savings accounts; improve access to long-term care services and coverage; and simplify the administration of health insurance and for other purposes. See also, *HIPAA 5010* in the ***Important Provider Information*** section of this handbook.

## Initial denial

A written decision or explanation of benefits (EOB) denying a TRICARE claim, a request for pre-authorization or a request by a provider for approval as an authorized TRICARE provider, on the basis that the service or provider does not meet TRICARE coverage criteria.

## Laboratory Developed Tests

A laboratory-developed test (LDT) is a diagnostic test that is designed, manufactured and used within a single laboratory. For an LDT to be considered for coverage certain criteria must be met.

## Letters of Attestation (LOA)

Health Net Federal Services, LLC (HNFS) offers LOAs for several limited benefits. You can attach the LOA instead of clinical documentation to your online request, which will expedite the review process.

## Managed care

A health care model under which an organization delivers health care to enrolled members and controls costs by closely supervising and reviewing the delivery of health care.

## Medical emergency

TRICARE defines an emergency as a serious medical condition that the average person would consider a threat to life, limb or eyesight.

## Medically necessary

Appropriate and necessary treatment of the beneficiary's illness or injury according to accepted standards of medical practice and TRICARE policy. Medical necessity must be documented in clinical notes.

## Military hospital or clinic

A medical facility owned and operated by the uniformed services and usually located on or near a military base. Also known as a military medical treatment facility.

## National Drug Code (NDC)

The U.S. Food and Drug Administration (FDA) requires companies engaged in the manufacture, preparation, propagation, compounding, or processing of a drug product to register with the FDA and provide a list of all drugs manufactured for commercial distribution. Drug products are identified and reported using a unique three-segment number called an NDC. NDCs can be found on the **Electronic Drug Registration and Listing System** published by the FDA.

## National Guard and Reserve

The National Guard and Reserve includes the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air and Space Force National Guard, the Air Force Reserve, and the Coast Guard Reserve.

## National Provider Identifier (NPI)

The NPI is a 10-digit number used to identify providers in standard electronic transactions. It is a requirement of the Health Insurance Portability and Accountability Act of 1996.

## Network provider

A network provider is a professional or institutional provider who has an agreement with Health Net Federal Services, LLC (HNFS) to provide care at a contracted rate. A network provider agrees to file claims and handle other paperwork for TRICARE beneficiaries. A network provider accepts the negotiated rate as payment in full for services rendered.

## Non-availability statement (NAS)

An NAS is a certification from a military hospital or clinic stating that a specific health care service or procedure cannot be provided.

## Non-network provider

A non-network provider does not have an agreement with Health Net Federal Services, LLC (HNFS) but is authorized to provide care to TRICARE beneficiaries. There are two types of non-network providers: participating and nonparticipating. Nonparticipating providermkjop0A nonparticipating provider is a TRICARE-authorized hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to TRICARE beneficiaries but does not have an agreement and does not accept the TRICARE-allowable charge or file claims for TRICARE beneficiaries. A nonparticipating provider may only charge up to 15% above the TRICARE-allowable charge.

## North Atlantic Treaty Organization (NATO) member

A member of a foreign NATO nation's armed forces who is on active duty and who, in connection with official duties, is stationed in or passing through the United States.

## Other health insurance (OHI)

Any non-TRICARE health insurance that is not considered a supplement is considered OHI. This insurance is acquired through an employer, entitlement program or other source. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, State Victims of Crime Compensation Programs, the Indian Health Service or other programs or plans as identified by the Defense Health Agency (DHA).

## Outpatient Prospective Payment System (OPPS)

TRICARE OPPS is used to pay claims for hospital outpatient services. TRICARE OPPS is based on nationally established ambulatory payment classification (APC) payment amounts and standardized for geographic wage differences that include operating and capital-related costs directly related and integral to performing a procedure or furnishing a service in a hospital outpatient department.

## Participating provider

A provider who has agreed to file claims for TRICARE beneficiaries, accept payment directly from TRICARE and accept the TRICARE-allowable charge as payment in full for services received. Non-network providers may participate on a claim-by-claim basis. Providers may seek payment of applicable copayments, cost-shares and deductibles from the beneficiary. Under the TRICARE Outpatient Prospective Payment System (OPPS), all hospitals that are Medicare-participating providers must, by law, also participate in TRICARE for inpatient and outpatient care.

## Peer review organization

An organization charged with reviewing provider quality and medical necessity.

## Per diem

A reimbursement methodology based on a per-day rate that is currently used for mental health care institutions and partial hospitalization programs (PHPs).

## Personally Identifiable Information (PII)

Information about an individual that identifies, links, relates, is unique to, or describes him or her (for example, Social Security number; age; military rank; civilian grade; marital status; race; salary; telephone numbers; and other demographic, biometric, medical, and financial information).

## Point-of-Service

An option that allows TRICARE Prime or TRICARE Prime Remote beneficiaries to obtain medically necessary services – inside or outside the TRICARE network – from someone other than their primary care manager without first obtaining a pre-authorization or referral. Using the **point-of-service** option results in a deductible and higher out-of-pocket expenses for the beneficiary. The **point-of-service** option does not apply to ADSMs.

## Pre-authorization

Pre-authorizations are for certain services and/or procedures that require HNFS to review and approve before services are provided. Some services and/or procedures that require pre-authorization include certain mental health care, hospitalization, surgical, and therapeutic procedures.

## Primary care manager (PCM)

A TRICARE civilian network provider or military hospital or clinic provider who provides primary care services to TRICARE Prime and TRICARE Prime Remote (TPR) beneficiaries. A PCM is either selected by the beneficiary or assigned by the military hospital's Commander or his or her designated appointee. TPR beneficiaries may choose a non-network provider if a network provider is not available.

## Prospective review

A screening process used to evaluate the medical necessity and appropriateness of a treatment or service proposed. The review is prospective (before the care or service is performed) and criteria-based using InterQual®. A registered nurse (RN), physician assistant (PA), mental health care provider, or physician performs reviews.

## Protected health information (PHI)

PHI is any individually identifiable health information that relates to a patient's past, present, or future physical or mental health and related healthcare services. Protected health information may include demographics, documentation of symptoms, examination and test results, diagnoses, and treatments.

## Reconsideration or appeal

A formal written request by an appropriate appealing party or an appointed representative to resolve a disputed statement of fact.

## Referral

The process of sending a patient to another professional provider (physician or mental health care provider) for an evaluation or a health care service that the referring source believes is necessary but is not prepared or qualified to provide. Referrals are required for most services for TRICARE Prime beneficiaries. Referrals are always required for active duty service members (ADSMs – except in the case of an emergency) for services provided by a network provider, other than the primary care manager (PCM).

## Region

A geographic area determined by the federal government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

## Resource sharing agreement (RSA)

There are two types of RSAs:

- External RSAs are arrangements that allow military providers to render medical services to TRICARE beneficiaries in civilian network medical facilities.
- Internal RSAs are arrangements that allow civilian providers into the military hospital system to render medical services to TRICARE beneficiaries.

## Retrospective review

Review of a beneficiary's medical record that occurs after services have been rendered.

## Right of first refusal (ROFR)

A military hospital or clinic review of civilian pre-authorizations and referrals received by HNFS to determine if the military hospital or clinic is able to provide the requested services.

## Social Security number (SSN)

An SSN is a number assigned by the federal government for the purposes of identifying a specific individual and taxpayer.

### Split enrollment

Refers to multiple family members enrolled in TRICARE Prime under different TRICARE regions or regional contractors.

### Sponsor

The sponsor is the ADSM or retiree through whom family members are eligible for TRICARE.

### Supplemental Health Care Program (SHCP)

The SHCP is a program for eligible uniformed services members and other designated patients who require medical care that is not available at a military hospital or clinic. Because services are not available at a military hospital or clinic, these beneficiaries must be referred to a network provider.

### Supplemental insurance

Supplemental insurance includes health benefit plans that are specifically designed to supplement TRICARE Select benefits. Unlike other health insurance plans, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

### Tax Identification Number (TIN)

A TIN is a number assigned by the state in which a business or entity is operated that identifies an entity for filing and paying taxes related to the business or entity.

### Transitional care

Transitional care is a program that is designed for all beneficiaries to ensure a coordinated approach takes place across the continuum of care.

### Treatment plan

A treatment plan is a multidisciplinary care plan for each beneficiary in active case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, military resources, all funding options, treatment goals, and assessment of the beneficiary environment. The plan is updated monthly and modified when appropriate. These plans are developed in collaboration with the attending physician and beneficiary or parent/guardian.

### TRICARE-allowable charge

The **TRICARE-allowable charge** (also called allowable charge) is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The TRICARE-allowable charge is normally the lesser of the:

- Actual billed charge;
- CMAC; or
- Prevailing charge (or amount derived from a conversion factor) made for a given procedure, adjusted to reflect local economic conditions as detailed in the **TRICARE Reimbursement Manual (TRM)**.

For example, if the TRICARE-allowable charge for a service is $90 and the billed charge is $50, TRICARE will pay $50 (actual billed charge); if the billed charge is $100, TRICARE will pay $90 (the TRICARE-allowable charge). In the case of inpatient hospital payments, the diagnosis-related group (DRG) rate is the TRICARE-allowable charge, regardless of the billed amount. For network providers, the TRICARE-allowable charge is the lesser of the contracted rate and the maximum amount TRICARE would authorize if the service had been furnished by a non-network participating provider.

### TRICARE-authorized provider

A provider who meets TRICARE's licensing and certification requirements and has been authorized by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (such as laboratory and radiology providers), and pharmacies.

### TRICARE regional contractor

A civilian health care partner of the Military Health System that administers TRICARE in one of the TRICARE regions. A regional contractor (for example, HNFS helps combine the services available at military hospitals or clinics with those offered by the TRICARE network of civilian hospitals and providers to meet the health care needs of TRICARE beneficiaries.

### UB-04

The UB-04 form is used by hospitals and other institutional providers to bill government and commercial health plans; this form must be used exclusively for institutional billing.

### Urgent care

TRICARE defines urgent care services as medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately but requires professional attention within 24 hours.

## Forms

Forms in the following categories are available at **www.tricare-west.com**:

- Appeals
- Authorizations
- Autism Care Demonstration
- Claims
- Electronic Data Interchange (EDI)
- Fraud, Waste and Abuse
- Grievances
- Medical Management
- Mental Health
- Military Hospital or Clinic Use Only
- Network Providers
- Non-Covered Services
- Non-Network Providers
- Other Health Insurance
- Patient Rights
- Privacy

# Health Insurance Claim Form (1500) Instructions

Claims must be submitted on the 1500 claim form for professional services. The following information is required on every claim:

| | |
|---|---|
| **BOX 1** | Indicate that this is a TRICARE claim by checking the box under "TRICARE." |
| **BOX 1a** | Sponsor's Social Security number or DOD Benefits Number. The sponsor is the person that qualifies the patient for TRICARE benefits. |
| **BOX 2** | Patient's name. |
| **BOX 3** | Patient's date of birth and sex. |
| **BOX 4** | Sponsor's full name. Do not complete if "self" is checked in Box 6. |
| **BOX 5** | Patient's address including ZIP code. This must be a physical address. Post office boxes are not acceptable. |
| **BOX 6** | Patient's relationship to sponsor. |
| **BOX 7** | Sponsor's address including ZIP code. |
| **BOX 8** | Reserved for National Uniform Claim Committee (NUCC) use. |

**Note:** Box 11d should be completed prior to determining the need for completing Boxes 9a through 9d. If Box 11d is checked "Yes," Boxes 9a and 9d must be completed. In addition, if there is another insurance carrier, the mailing address of that insurance carrier must be attached to the claim form.

| | |
|---|---|
| **BOX 9d** | Name of insurance plan or program name where individual has other health insurance (OHI). |
| **BOX 10a–c** | Check to indicate whether employment or accident related. (In the case of an auto accident, indicate the state where it occurred.) |
| **BOX 10d** | Claim codes (Designated by NUCC). |

**Note:** Box 11 through Box 11c questions pertain to the sponsor.

| | |
|---|---|
| **BOX 11** | Indicate policy group or Federal Employees Compensation Act (FECA) number (if applicable). |
| **BOX 11a** | Sponsor's date of birth and sex, if different than Box 3. |
| **BOX 11b** | Other claim identification (ID – designated by NUCC). |
| **BOX 11c** | Indicate "TRICARE" in this field. |
| **BOX 11d** | Indicate if there is another health insurance plan primary to TRICARE in this field. |
| **BOX 12** | Patient's or authorized person's signature and date; release of information. A signature on file is acceptable provided signature is updated annually. |
| **BOX 13** | Insured's or authorized person's signature. This authorizes payment to the physician or supplier. |
| **BOX 14** | Date of current illness, injury or pregnancy (LMP). |
| **BOX 15** | First date (MM/DD/YY) had same or similar illness (not required, but preferred). |
| **BOX 16** | Dates patient unable to work (not required, but preferred). |
| **BOX 17** | Name of referring physician (very important to include this information). |
| **BOX 17a** | ID (non-National Provider Identifier [NPI]) number of referring physician with qualifier. |
| **BOX 17b** | Referring physician NPI. |
| **BOX 18** | Admit and discharge date of hospitalization. |
| **BOX 19** | Referral number. |
| **BOX 20** | Check if lab work was performed outside the physician's office and indicate charges by the lab. If an outside provider (such as, a laboratory) performs a service, claims should include modifier "90" or indicate "Yes" in this block. |
| **BOX 21a–l** | Indicate at least one, and up to 12, specific diagnosis codes. |
| **BOX 23** | Pre-authorization number. |
| **BOX 24a** | Date of service. |
| **BOX 24b** | Place of service. |
| **BOX 24c** | EMG (emergency) indicator |
| **BOX 24d** | CPT®/HCPCS procedure code with modifier, if applicable. |
| **BOX 24e** | Diagnosis code reference number (pointer). |
| **BOX 24f** | Charges for listed service. |
| **BOX 24g** | Days or units for each line item. |
| **BOX 24h** | Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-related services/family planning response and appropriate reason code (if applicable). |
| **BOX 24i** | Qualifier identifying if the number is a non-NPI ID. |
| **BOX 24j** | Rendering provider ID number. Enter the non-NPI ID number in the shaded area. Enter the NPI number in the unshaded area. |
| **BOX 25** | Physician's/supplier's Tax Identification Number (TIN). |
| **BOX 26** | Patient's account number (not required, but preferred). |
| **BOX 27** | Indicate whether provider accepts TRICARE assignment. |
| **BOX 28** | Total charges submitted on a claim. |
| **BOX 29** | Amount paid by patient or other carrier. |
| **BOX 31** | Authorized signature. |
| **BOX 32** | Name and address where services were rendered. This must be the actual physical location. If you use an independent billing service, please do not use the billing service's address. |
| **BOX 32a** | NPI of the service facility location. |

| | |
|---|---|
| **BOX 32b** | Two-digit qualifier identifying the non-NPI number followed by the ID number (if necessary). |
| **BOX 33** | Physician's/supplier's billing name, address, ZIP code, and phone number. |
| **BOX 33a** | NPI of billing provider. |
| **BOX 33b** | Two-digit qualifier identifying the non-NPI number followed by the ID number (if necessary). |

## 1500 Claim Form Place of Service Codes

| | |
|---|---|
| 11 | Office |
| 12 | Home |
| 15 | Mobile unit |
| 17 | Walk-in retail health clinic |
| 19 | Off-campus outpatient hospital |
| 21 | Inpatient hospital |
| 22 | On-campus outpatient hospital |
| 23 | Emergency room – hospital |
| 24 | Ambulatory surgical center |
| 25 | Birthing center |
| 26 | Military hospital or clinic |
| 31 | Skilled nursing facility |
| 32 | Nursing facility |
| 33 | Custodial care facility |
| 34 | Hospice |
| 41 | Ambulance, land |
| 42 | Ambulance, air or water |
| 51 | Inpatient psychiatric facility |
| 52 | Psychiatric facility, partial hospitalization |
| 53 | Community mental health center |
| 54 | Intermediate care center/mentally retarded |
| 55 | Residential substance abuse treatment facility |
| 56 | Psychiatric residential treatment center |
| 61 | Comprehensive inpatient rehabilitation facility |
| 62 | Comprehensive outpatient rehabilitation facility |
| 65 | End-stage renal disease treatment facility |
| 71 | State or local public health clinic |
| 72 | Rural health clinic |
| 81 | Independent laboratory |
| 99 | Other unlisted facility |

## West Region Service Codes

| | |
|---|---|
| Ambulance services: | F |
| Anesthesia: | 4 |
| Anesthesia exception: | 6 |
| Assistant at surgery: | 0 |
| Behavioral health: | C |
| Birthing center: | S |
| Consultation: | 9 |
| Darbepoetin: | 6 |
| Durable medical equipment: | G – Purchase; or<br>H – Rental |
| Epoetin alpha injection codes: | 6 |
| Home infusion therapy: | G |
| Injections: | 6 |
| Maternity: | 3 |
| Medical: | 6 |
| Mobile Health Providers: | 5 |
| Neurology: | 6 or P |
| Orthotic/prosthetic procedures: | G |
| Pathology/laboratory: | P or 8 |
| Physical therapy: | D |
| Radiation oncology: | E |
| Radiation therapy: | P or E |
| Radiology: | P or 5 |
| Supplies: | G |
| Surgery: | 2 |

## Uniform Bill Form (UB-04) Instructions

The following listing of UB-04 form locators is a summary of the Form Locator information.

| | |
|---|---|
| **FL 1** | Provider name, physical address and telephone number required. |
| **FL 2** | Pay-to name and address required. |
| **FL 3a** | Patient control number. |
| **FL 3b** | Medical/health record number. |
| **FL 4** | Type of bill (three-character alphanumeric identifier). |
| **FL 5** | Federal Tax Identification Number. |
| **FL 6** | Statement covers period (from–through). |

The beginning and ending dates of the period included on the bill are shown in numeric fields (MM-DD-YY).

| | |
|---|---|
| **FL 7** | Not required. |
| **FL 8a–b** | Patient's name (surname first, first name and middle initial, if any). Enter the patient's SSN in field "a." Enter the patient's name in field "b." |

| | |
|---|---|
| **FL 9a–e** | Patient's address including ZIP code. This must be a physical address. Post office boxes are not acceptable. |
| **FL 10** | Patient's birth date (MM-DD-YYYY). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled. |
| **FL 11** | Patient's sex. This item is used in conjunction with FLs 66–69 (diagnoses) and FL 74 a–e (surgical procedures) to identify inconsistencies. |
| **FL 12** | Admission date. |
| **FL 13** | Admission hour. |
| **FL 14** | Type of admission. This code indicates priority of the admission. |
| **FL 15** | Source of admission. This code indicates the source of admission or outpatient registration. |
| **FL 16** | Discharge hour. |
| **FL 17** | Patient status. This code indicates the patient's status as of the "through" date of the billing period (FL 6). |
| **FLs 18–28** | Condition codes. |
| **FL 29** | Accident state. |
| **FL 30** | Not required. |
| **FLs 31–34** | Occurrence codes and dates. |
| **FLs 31–34** | Occurrence codes and dates. |
| **FLs 35–36** | Occurrence span code and dates. |
| **FL 37** | Not required. |
| **FL 38** | Responsible party name and address. |
| **FLs 39–41** | Value codes and amounts. |
| **FL 42** | Revenue code. |
| **FL 43** | Revenue description – A narrative description or standard abbreviation for each revenue code in FL 42. Descriptions or abbreviations correspond to the revenue codes. |
| **FL 44** | HCPCS/rates. When coding HCPCS, enter the HCPCS code describing the procedure. May be required for correct reimbursement. |
| **FL 45** | Service date. If submitting claims for outpatient services, report a separate date for each day of service. |
| **FL 46** | Service units. The entries in this column quantify services by revenue category (for example, number of days, a particular type of accommodation, pints of blood). Up to seven digits may be entered. |
| **FL 47** | Total charges. |
| **FL 48** | Non-covered charges. The total non-covered charges pertaining to the related revenue code in FL 42 is entered here. |
| **FL 49** | Not required. |
| **FL 50a–c** | Payer identification. Enter the primary payer on line A. |
| **FL 51a–c** | Health Plan Identification Number. |
| **FL 52a–c** | Release of information. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file. |
| **FL 53a–c** | Assignment of benefits certification indicator. |
| **FL 54a–c** | Prior payments. For all services other than inpatient hospital and skilled nursing facility services, the sum of any amount(s) collected by the provider from the patient toward deductibles and/or co-insurance are entered on the patient (last) line of this column. |
| **FL 55a–c** | Not required. |
| **FL 56** | NPI |
| **FL 57a–c** | Other Provider Identifier Number. |
| **FL 58a–c** | Insured's name. |
| **FL 59a–c** | Patient's relationship to insured. |
| **FL 60a–c** | Certificate/Social Security number/health insurance claim/identification number. |
| **FL 61a–c** | Group name. Indicate the name of the insurance group or plan. |
| **FL 62a–c** | Insurance Group Number. |
| **FL 63a–c** | Treatment authorization code. Contractor specific or HHA PPS OASIS code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient pre-admission or pre-procedure, the authorization number is required for all approved admissions or services. |
| **FL 64a–c** | Document control number (DCN). Original DCN number of the claim to be adjusted. |
| **FL 65a–c** | Employer name. Name of the employer that provides health care coverage for the individual identified on FL 58. |
| **FL 66** | Diagnosis and procedure code qualifier (ICD Version Indicator) |
| **FL 67** | Principal diagnosis code. Centers for Medicare and Medicaid Services (CMS) only accepts ICD- 10-CM diagnostic and procedural codes which use definitions contained in Department of Health and Human Services Publication Number (PHS) 89-1260 or CMS-approved errata supplements to this publication. Diagnosis codes must be full ICD-10-CM diagnosis codes, including all digits where applicable. |
| **FL 67a–q** | Other diagnosis codes. |
| **FL 68** | Not required. |
| **FL 69** | Admitting diagnosis. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's hospital admission. |
| **FL 70a–c** | Patient's reason for visit. |
| **FL 71** | Prospective payment system (PPS) code. |
| **FL 72** | External cause of injury code. |
| **FL 73** | Not required. |

| | |
|---|---|
| **FL 74** | Principal procedure code and date. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes or for which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis. |
| **FL 74a–e** | Other procedure codes and dates. The full ICD-10-CM procedure codes, including all seven digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL 74). The date of each procedure is shown in the date portion of Item 74, as applicable (MM-DD-YY). |
| **FL 75** | Not required. |
| **FL 76** | Attending/referring physician identification (ID). |
| **FL 77** | Operating physician name and identifiers. |
| **FL 78–79** | Other physician ID. |
| **FL 80** | Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Authorized signature of non-network providers. |
| **FL 81a–d** | Code field. |

## Condition Codes

| | |
|---|---|
| **02** | Condition is employment related |
| **03** | Patient covered by insurance not reflected here |
| **06** | End-stage renal disease patient in first 30 months of entitlement covered by employer group health insurance |
| **08** | Beneficiary would not provide information concerning other insurance coverage |
| **18** | Maiden name retained |
| **19** | Child retains mother's name |
| **31** | Patient is student (full-time – day) |
| **33** | Patient is student (full-time – night) |
| **34** | Patient is student (part-time) |
| **36** | General care patient in a special unit |
| **38** | Semi-private room not available |
| **39** | Private room medically necessary |
| **40** | Same-day transfer |
| **41** | Partial hospitalization |
| **46** | Non-availability statement on file |
| **48** | Psychiatric residential treatment centers for children and adolescents |
| **55** | Skilled nursing facility bed not available |
| **56** | Medical appropriateness |
| **60** | Day outlier |
| **61** | Cost outlier |
| **67** | Beneficiary elects not to use lifetime reserve days |
| **A0** | TRICARE External Partnership Program |
| **A2** | Physically Handicapped Children's Program |
| **C1** | Approved as billed |
| **C2** | Automatic approval as billed based on focused review |
| **C3** | Partial approval |
| **C4** | Admission/services denied |
| **C5** | Post-payment review applicable |
| **C6** | Admission pre-authorization |
| **C7** | Extended authorization |
| **G0** | Distinct medical visit (OPPS) |

## Occurrence Span Codes

| | |
|---|---|
| **01** | Auto accident |
| **02** | No fault insurance involved – including auto accident/other |
| **03** | Accident/tort liability |
| **04** | Accident/employment related |
| **05** | Accident/no medical or liability coverage |
| **06** | Crime victim |
| **21** | Date UR notice received |
| **22** | Date active care ended |
| **24** | Date insurance denied |
| **25** | Date benefits terminated by primary payer |
| **26** | Date skilled nursing facility bed became available |
| **27** | Date of hospice certification or recertification |
| **28** | Date comprehensive outpatient rehabilitation plan established or last reviewed |
| **29** | Date outpatient physical therapy plan established or last reviewed |
| **30** | Date outpatient speech pathology plan established or last reviewed |
| **31** | Date beneficiary notified of intent to bill (accommodations) |
| **32** | Date beneficiary notified of intent to bill (procedures or treatments) |
| **33** | First day of the Medicare coordination period for end-stage renal disease beneficiaries covered by employer group health plan |

## Value Codes and Amounts

| | |
|---|---|
| **01** | **Most common semiprivate rate** |
| **02** | **Hospital has no semi-private rooms** |
| **05** | **Professional component included in charges and also billed separate to carrier** |
| **30** | **Pre-admission testing** |
| **31** | **Patient liability amount** |
| **37** | **Pints of blood furnished** |
| **46** | **Number of grace days** |