



# TRICARE<sup>®</sup> Provider Handbook

Your guide to TRICARE programs,  
policies, and procedures

**June 2013**





**June 2013**

## **An Important Note about TRICARE® Program Information**

This TRICARE Provider Handbook (this Handbook) will assist you in delivering TRICARE benefits and services. At the time of printing, the information in this Handbook is current, but must be read in light of governing regulations.

It is important to recognize that TRICARE policies and benefits are governed by federal regulations. Changes to TRICARE programs are continually made as federal regulations are revised and updated. Where required by law, updates will be provided in writing. We may also use additional channels (such as mail, internet, email, phone and fax) to communicate with you in the event of such a change. When required by law, we will notify you prior to implementation of a change.

To the extent that some requirements are applicable only in certain states at the time of printing, we have indicated that in this Handbook.

The codes and code ranges listed in this Handbook are current at the time of publication. Codes and coding requirements, as established by the organizations that create the codes, and may periodically change. Please refer to the applicable coding guide for appropriate codes or visit us online for more information.

For the most recent information, visit UnitedHealthcare Military & Veterans (may also be referred to as UnitedHealthcare) at [uhcmilitarywest.com](http://uhcmilitarywest.com) or call (877) 988-WEST/(877) 988-9378. Please note that [uhcmilitarywest.com](http://uhcmilitarywest.com) will not be fully operational until UnitedHealthcare Military & Veterans begins delivering health care to TRICARE beneficiaries. More information regarding TRICARE is available at [www.tricare.mil](http://www.tricare.mil).

## **Using This *TRICARE Provider Handbook***

This Handbook provides you and your staff with important information about TRICARE while 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.

This Handbook is updated as needed, but not less than annually, and is available electronically on [uhcmilitarywest.com](http://uhcmilitarywest.com). You may request additional copies of the *TRICARE Provider Handbook* from UnitedHealthcare at (877) 988-WEST/(877) 988-9378.

TRICARE program changes and updates are communicated periodically through the *TRICARE Provider News* publications.

Thank you for your service to America's heroes and their families. For assistance, you should contact the Provider Service Line.

For contact information, visit the "Contact Provider Service Line" page on [uhcmilitarywest.com](http://uhcmilitarywest.com).

### **Give Us Your Opinion**

We continually strive to improve our materials and value your input as we plan future updates. Please provide feedback on this Handbook by participating in the survey available at [www.tricare.mil/evaluations/handbooks](http://www.tricare.mil/evaluations/handbooks).

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# Welcome to TRICARE and the West Region

## What Is TRICARE?

TRICARE is the uniformed services\* health care program for active duty service members and their families, retired service members and their dependents, members of the National Guard and Reserve and their families, survivors, and others who are eligible. TRICARE's primary objective is to deliver world-class health care benefits for all Military Health System (MHS) beneficiaries that provide the highest level of patient satisfaction.

TRICARE brings together the health care resources of the uniformed services and networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide access to high-quality health care services while maintaining the capability to support military operations.

TRICARE is available worldwide. In the United States, TRICARE is divided into 3 separate regions – TRICARE North, TRICARE South, and TRICARE West.

In the United States, TRICARE is managed jointly by the TRICARE Management Activity (TMA) and TRICARE Regional Offices. TMA has contracted with civilian managed care support contractors in the North, South, and West regions to assist TRICARE regional directors and military treatment facility (MTF) commanders in operating an integrated health care delivery system.

\* The uniformed services include the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, the Commissioned Corps of the U.S. Public Health Service, and the Commissioned Corps of the National Oceanic and Atmospheric Administration.

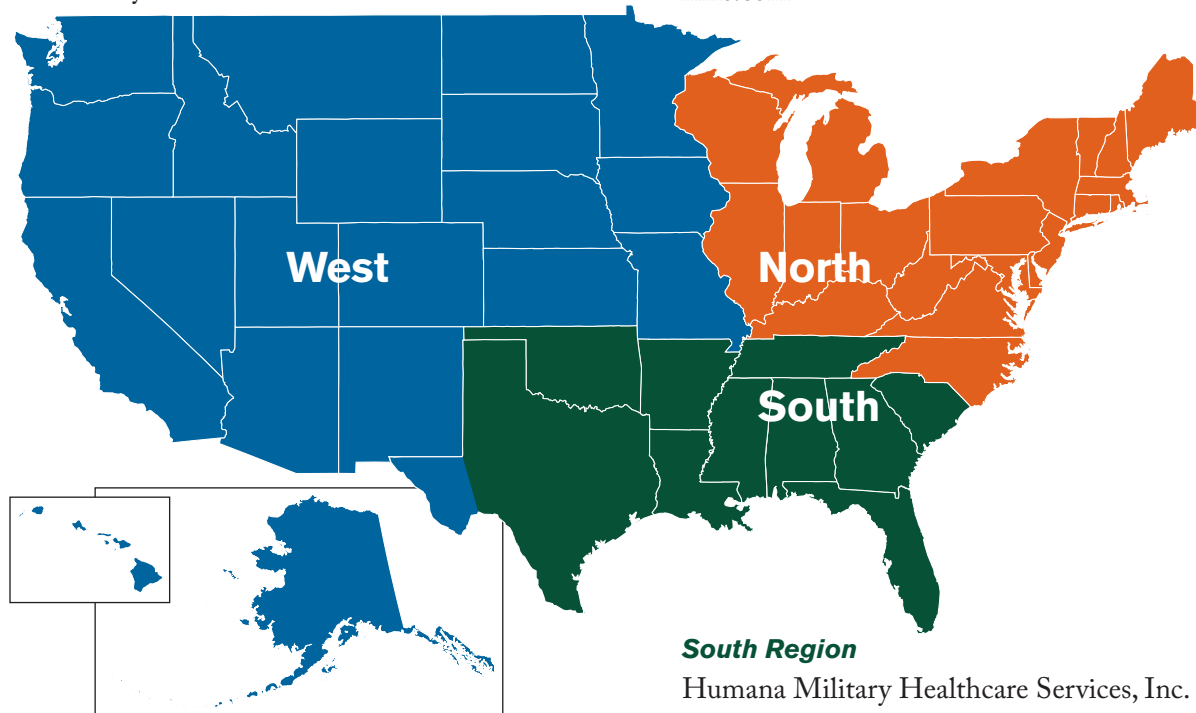
## TRICARE Regions

### West Region

UnitedHealthcare Military & Veterans  
Provider Services Line:  
(877) 988-WEST/(877) 988-9378  
uhcmilitarywest.com

### North Region

Health Net Federal Services, LLC  
Customer Service Line:  
(877) TRICARE/(877) 874-2273  
hnfs.com



### South Region

Humana Military Healthcare Services, Inc.  
Customer Service Line: (800) 444-5445  
humana-military.com

# Your Managed Care Support Contractor

UnitedHealthcare is responsible for administering the TRICARE program for more than 2.9 million TRICARE beneficiaries in the 21 state-TRICARE West Region. The West Region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excluding the Rock Island Arsenal area), Kansas, Minnesota, Missouri (excluding the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner only, including El Paso), Utah, Washington, and Wyoming.

UnitedHealthcare is committed to preserving the integrity, flexibility, and durability of MHS by offering TRICARE beneficiaries access to the finest health care services available, thereby contributing to the continued superiority of U.S. combat readiness.

## PGBA, LLC. (PGBA)

PGBA is the UnitedHealthcare contractor for claims processing. PGBA has extensive experience with every aspect of TRICARE claims-processing activities, including the development of claims submission options. See the *Claims Processing and Billing Information* section of this Handbook for specific options and instructions for filing claims electronically. Filing claims electronically shortens reimbursement time and enhances the accuracy of submitted claims.

## Provider Resources

Many national and regional resources are available if you or your staff has questions or concerns about TRICARE programs, policies, or procedures; or if you need assistance coordinating care for a TRICARE beneficiary.

## TRICARE Manuals Online

This Handbook is a summary of the TRICARE program regulations and requirements contained in the *TRICARE Operations Manual* 6010.56-M, February 2008, the *TRICARE Policy Manual* 6010.57-M, February 2008, and the *TRICARE Reimbursement Manual* 6010.58-M, February 2008. These manuals are available in their entirety online at <http://manuals.tricare.osd.mil> and are subject to change by TRICARE Management Activity (TMA).

## UnitedHealthcare Website

UnitedHealthcare has developed an area of its website for providers at [uhcmilitarywest.com](http://uhcmilitarywest.com). **Please note that [uhcmilitarywest.com](http://uhcmilitarywest.com) will not be fully operational until UnitedHealthcare Military & Veterans begins delivering healthcare to TRICARE beneficiaries on or about April 1, 2013.**

Most providers can register for the website and receive access instantly.

Registering on [uhcmilitarywest.com](http://uhcmilitarywest.com) allows you to:

- Verify patient eligibility
- Research covered benefits and check referral/authorization and medical-review requirements for specific codes
- Check claim status

The public area of the website offers important information and the ability to:

- View the *TRICARE Provider Handbook*
- Download forms
- Read important updates about the TRICARE program and UnitedHealthcare processes
- Link to important reimbursement information
- View the prior authorization list
- Obtain information about the secure website



### **UnitedHealthcare's UHC Military West E-News**

UnitedHealthcare produces an electronic newsletter with the latest TRICARE news and information for providers. The *UHC Military West E-News* is the easiest way to receive important updates. More information about E-News and how to enroll for updates will be forthcoming.

### **Online TRICARE Provider Directory**

To make referrals easier, UnitedHealthcare has several search options in the online network TRICARE Provider Directory on [uhcmilitarywest.com](http://uhcmilitarywest.com).

To confirm your information is correct, please check the online UnitedHealthcare TRICARE Provider Directory on [uhcmilitarywest.com](http://uhcmilitarywest.com). If your information needs to be updated please contact the Provider Service Line at (877) 988-9378 so that UnitedHealthcare can display your current information for TRICARE beneficiaries to obtain additional information about your practice, facility, or services. Please contact the Provider Service Line if you have any questions.

Note: Not all TRICARE network providers are listed in the directory. Emergency room physicians, urgent care physicians, and some other hospital-based providers may not be listed. Non-network providers are not listed in the online TRICARE Provider Directory. Non-network providers with demographic changes should contact PGBA directly.

Information in the TRICARE Provider Directory is subject to change without notice. Before beneficiaries choose a network provider, they are encouraged to call and confirm the address and the availability of new-patient appointments.

### **UnitedHealthcare's Interactive Voice Response System (IVR)**

When you call (877) 988-WEST / (877) 988-9378, UnitedHealthcare offers an IVR system to assist providers with routine questions. The IVR system uses natural speech recognition to understand words, numbers, and phrases. Follow the greeting and prompts to get quick information and accurate answers on many topics, such as verifying beneficiary eligibility and checking the status of claims.

A guide with tips on using UnitedHealthcare's IVR system is available on [uhcmilitarywest.com](http://uhcmilitarywest.com) → Quick Reference Guides.

## **Important Provider Information**

Contracted TRICARE providers are obligated to abide by the rules, procedures, policies, and program requirements as specified in this Handbook, which is a summary of the TRICARE regulations and manual requirements related to the program.

### **TRICARE Policy Resources**

The statutes governing the TRICARE Program are found in Chapter 55 of Title 10 of the United States Code of Federal Regulations and Title 32, part 1099 of the United States Code of Federal Regulations (CFR).

The Department of Defense (DoD), through TMA, directs UnitedHealthcare on how to administer the TRICARE program. This direction comes through modifications to the CFR. The *TRICARE Operations Manual*, *TRICARE Policy Manual*, and *TRICARE Reimbursement Manual* are updated continually to reflect changes in the CFR. Depending on the complexity of the law and federal funding, it may take a year or more before direction from the DoD is given through TMA and UnitedHealthcare can begin administration of the new policy.

## **Social Security Number Reduction Plan**

In response to the growing need to protect beneficiaries' identification (ID) information, the DoD is removing Social Security numbers (SSNs) from DoD ID cards. SSNs are being replaced with 10-digit DoD ID numbers. If a beneficiary has DoD benefits, he or she will also have a DoD Benefits Number (DBN) printed on the card. This is a unique number that is required in order to align beneficiaries' records with their treatments. The new DBN is above the bar code on the back of the uniformed services ID card. Although SSNs are being removed from ID cards, TRICARE continues to base all operations (e.g., eligibility verification, claims submission, appeals) on the sponsor's SSN. You may ask a TRICARE beneficiary to provide his/her sponsor's SSN verbally or on other standard documentation required by your practice or facility. Until the ID cards expire, the current ID cards will remain active and the eligibility process will not change.

Note: Changes are made when beneficiaries renew their ID cards. Sponsor ID cards will retain the last 4 digits of their SSNs; however, this information will not appear on family-member ID cards.

## **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

HIPAA was enacted on August 21, 1996, to improve portability of health insurance coverage and to simplify health care billing through the development of electronic data interchange; and to combat waste, fraud, and abuse. The U.S. Department of Health and Human Services (HHS) developed regulations implementing HIPAA's administrative simplification provisions, specifically, Transactions and Code Sets Rules, and rules on Employer Identifier and National Provider Identifier (NPI) numbers.

The impending use of electronic data caused privacy concerns among the public. Therefore, Congress included a mandate in HIPAA to develop privacy protections. In the absence of federal legislation, HHS published regulations developing privacy protections. These rules became effective April 14, 2003, and additional regulations on security of electronic health information took effect in 2005. Congress subsequently enacted significant amendments to these privacy and security rules in the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was part of the 2009 stimulus legislation.

The DoD Military Health System (MHS) generally adheres to the HHS rules implementing administrative simplification, including privacy and security. The MHS also complies with the 1974 Privacy Act. For more information on MHS privacy procedures, see DoD Regulations 5400.1R, 6025.18-R, and 8580.02-R, all of which are available at [www.dtic.mil/whs/directives/corres/pub1.html](http://www.dtic.mil/whs/directives/corres/pub1.html). Additional information is available on the TMA Privacy Office website at [www.tricare.mil/tma/privacy](http://www.tricare.mil/tma/privacy).

For more TRICARE-specific information on HIPAA, refer to the *TRICARE Operations Manual*, Chapter 1, Section 5 and Chapter 19 at <http://manuals.tricare.osd.mil>.

TRICARE health plans, military treatment facilities (MTFs), providers, and their contractors and subcontractors are generally required to comply with the DoD's rules and the HIPAA administrative simplification rules, as amended by the HITECH Act, as applicable. The HIPAA requirements set forth in this Handbook are applicable to MHS providers.

In compliance with HIPAA portability requirements, the MHS, through the Defense Manpower Data Center Support Office, automatically issues certificates of creditable coverage to beneficiaries who lose TRICARE coverage. For additional information, visit the TRICARE website at [www.tricare.mil/tma/hipaa/cocc.aspx](http://www.tricare.mil/tma/hipaa/cocc.aspx).

### **HIPAA Privacy Rule**

The following is only a brief introduction to selected aspects of the HIPAA Privacy Rule. TRICARE health care providers should consult the more detailed guidance materials available on the TMA Privacy Office website at [www.tricare.mil/tma/privacy](http://www.tricare.mil/tma/privacy).

The HIPAA Privacy Rule generally requires individual health care providers, institutional providers such as MTFs, their workforce members, and their contractors to use and disclose protected health information (PHI) only as permitted or required by the HIPAA Privacy Rule. PHI is individually identifiable health information, which includes demographic and payment information created and obtained by providers who deliver health services to patients. Examples of PHI include medical-record data (documentation of symptoms, examination and test results, diagnoses, treatments, and plans for future care or treatment) and billing documents.

The HIPAA Privacy Rule permits providers to use and disclose PHI without a patient's written authorization for purposes of treatment, payment, and health care operations. Health care operations include activities such as quality assessment, quality improvement, outcome evaluation, protocol and clinical-guidelines development, training programs, credentialing, medical review, legal services, and insurance.

The HIPAA Privacy Rule also permits uses and disclosures of PHI without a patient's authorization in various situations not involving treatment, payment, and health care operations. These situations include, for example, public health activities, health oversight activities, judicial and administrative proceedings, decedent situations, and research. In the MHS, one of the most important exceptions to the authorization requirement is the military-command exception. This permits limited disclosures of PHI about active duty service members (ADSMs) to their military commanders to determine fitness for duty or certain other purposes. Similarly, PHI of service members separating from the armed forces may be disclosed to the U.S. Department of Veterans Affairs (VA).

PHI may be used or disclosed for other purposes only with written authorization of the patient or the patient's personal representative. The authorization form must satisfy specific requirements under the HIPAA Privacy Rule.

Patients must be given the opportunity to agree or object to disclosure of their PHI in facility directories and disclosures to persons involved in their care. Written authorizations are not required in these cases.

Under the HIPAA Privacy Rule, beneficiaries have the right to:

- Receive a copy of the *Military Health System Notice of Privacy Practices*
- Request access to PHI
- Request amendment of PHI
- Request an accounting of PHI disclosures
- Request restrictions on, or confidential communications of, PHI use and disclosure
- File a complaint regarding any privacy infractions

Providers must also establish administrative, physical, and technical safeguards for PHI. Moreover, actual or possible unauthorized use or disclosure of PHI (a breach) may require notifying affected individuals and reporting to TMA and other government entities. For more information on responding to privacy breaches, visit [www.tricare.mil/tma/privacy/breach.aspx](http://www.tricare.mil/tma/privacy/breach.aspx).

### ***Military Health System Notice of Privacy Practices and Other Information Sources***

The *Military Health System Notice of Privacy Practices* informs beneficiaries about their rights regarding PHI and explains how PHI may be used or disclosed, who can access PHI, and how PHI is protected. The notice is published in 11 languages. Braille and audio versions are also available. Visit [www.tricare.mil/tma/privacy/hipaa-nopp.aspx](http://www.tricare.mil/tma/privacy/hipaa-nopp.aspx) to download copies of the Military Health System Notice of Privacy Practices for you and your staff.

Privacy officers are available for every MTF. 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 at [www.tricare.mil/hipaa](http://www.tricare.mil/hipaa). Beneficiaries and providers may also email inquiries to [privacymail@tma.osd.mil](mailto:privacymail@tma.osd.mil).

### **Release of Medical Records and Other Protected Health Information (PHI)**

PHI may be released to the individual who is the subject of the PHI and, unless contraindicated, to that individual's personal representative. Personal representatives include parents of unemancipated minors, guardians, and other persons who have legal authority to act on behalf of the individual with respect to health care decisions.

Contraindications may include circumstances involving unemancipated minors and applicable state laws, and abuse, neglect, or endangerment situations. Additionally, special care must be taken when PHI includes unusually sensitive medical conditions, such as:

- abortion
- pregnancy
- AIDS
- sexually transmitted diseases
- alcoholism or other substance abuse
- mental health conditions.

UnitedHealthcare representatives must comply with the Privacy Act of 1974 and HIPAA Privacy Rules when TRICARE beneficiaries call regarding claims and other patient benefit information.

If a person requests information on behalf of a TRICARE beneficiary, UnitedHealthcare may not disclose information until the proper legal paperwork is received. UnitedHealthcare will not disclose information to a person who:

- Calls on behalf of a spouse or adult child (as defined under applicable state law) who has not submitted an *Authorization to Disclose* form
- Is caring for a child whose deployed active duty sponsor has not submitted power of attorney documentation to allow disclosure of the child's medical information
- Is the spouse of a deployed ADSM who has not provided a valid power of attorney or other appropriate documentation to allow disclosure of the ADSM's medical information
- Is not shown to be the parent or other personal representative of a minor child whose PHI would be disclosed
- Is the spouse or family member of a deceased sponsor, but legal representative appointment documentation for the estate has not been submitted to UnitedHealthcare. (If there is no legal representative for the estate, the individual seeking the PHI must furnish a written statement of his or her relationship to the deceased and the provider should confer with legal counsel.)

To download the *Authorization to Disclose* form, go to [uhcmilitarywest.com](http://uhcmilitarywest.com) → Beneficiary → Find A Form → Privacy Release Forms.

If you have additional questions about the HIPAA Privacy Rule and TRICARE, visit the TMA Privacy and Civil Liberties Office website at [www.tricare.mil/tmaprivacy](http://www.tricare.mil/tmaprivacy) or the HHS Health Information Privacy website at [www.hhs.gov/ocr/privacy](http://www.hhs.gov/ocr/privacy).

### **HIPAA Security Rule**

The HIPAA Security Rule requires administrative, physical, and technical safeguards to assure the confidentiality, integrity, and availability of PHI in electronic form. Specific safeguards are not prescribed. Instead, the HIPAA Security Rule establishes general standards and associated implementation specifications. The implementation standards are either "required" (standards that must be implemented) or "addressable" (standards that must be

assessed and either implemented if reasonable and appropriate, or otherwise addressed with reasonable alternative measures and documentation of the assessment.)

TRICARE providers are expected to adhere to industry standards and regulatory developments on data-security protection. Additionally, providers should consult the guidance materials available on the TMA Privacy and Civil Liberties Office website at [www.tricare.mil/tmaprivacy](http://www.tricare.mil/tmaprivacy), which includes information on new regulations under the HITECH Act and any other legislative initiatives affecting data security.

### **HIPAA Transactions and Code Sets Rule**

The HIPAA Transactions and Code Sets Rule implemented electronic standards for certain administrative and financial health care transactions. As required by the HIPAA Standard Transactions and Code Sets Rule, the MHS and TRICARE apply HIPAA standards for electronic business functions.

For more information, visit the HIPAA and TRICARE Transaction and Code Sets website at [www.tricare.mil/tma/hipaa/transactions.aspx](http://www.tricare.mil/tma/hipaa/transactions.aspx).

HHS has published Final Rules to adopt updated versions of HIPAA Electronic Transactions and Code Sets. These Final Rules require compliance with X12 Version 5010 and NCPDP D.0 transactions no later than January 1, 2012, and as revised on September 5, 2012, compliance with ICD-10-CM and ICD-10-PCS no later than October 1, 2014.

### **HIPAA Employer Identifier Number (EIN)**

The National Employer Identifier Final Rule requires health care providers, plans, and clearinghouses to accept and transmit employer identification numbers (EINs) 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 IRS *Form W-2 Wage and Tax Statement* and is used to identify the employer in standard electronic health care transactions.

**HIPAA Electronic Transactions**

**Figure 2.1**

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

### **HIPAA National Provider Identifier (NPI)**

The HIPAA NPI Final Rule, published in the Federal Register, establishes the 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 (i.e., assignment of NPIs to providers) and NPI-associated data maintenance are conducted through the National Plan and 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 2 categories of health care providers. Entity Type 1 is for individuals, such as physicians, nurses, dentists, pharmacists, and physical therapists. Entity Type 2 is for organizations, such as hospitals, home health agencies, clinics, nursing homes, laboratories, and MTFs. 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 at <https://nppes.cms.hhs.gov> or download a paper application of the *National Provider Identifier (NPI) Application/Update Form* at [www.cms.hhs.gov/cmsforms/downloads/cms](http://www.cms.hhs.gov/cmsforms/downloads/cms). You may also request an application from the NPI Enumerator in one of the ways listed in Figure 2.2.

**NPI Enumerator Contact Information** **Figure 2.2**

<b>Phone</b>	(800) 465-3203 (800) 692-2326 (TTY)
<b>Email</b>	customerservice@npienumerator.com
<b>Mail</b>	NPI Enumerator P.O. Box 6059 Fargo, ND 58108-6059

For additional information, go to [uhcmilitarywest.com](http://uhcmilitarywest.com) → Claims/Payments → NPI.

For more information about NPIs, visit the Centers for Medicare and Medicaid Services website at [www.cms.hhs.gov/NationalProvIdentStand](http://www.cms.hhs.gov/NationalProvIdentStand). For TRICARE-specific information, visit [www.tricare.mil/tma/hipaa/identifiers.aspx](http://www.tricare.mil/tma/hipaa/identifiers.aspx).

## TRICARE Provider Types

TRICARE defines a provider as a person, business, or institution that renders health care services. For example, doctors are individual providers, hospitals are institutional providers, and ambulance companies are corporate providers. There are many other provider types. A provider must be authorized under TRICARE regulations and certified by UnitedHealthcare. Figure 2.3 on the following page provides an overview of TRICARE provider types.

Note: Active Duty Service Members (ADSMs) and civilian employees of the federal government who are health care providers are generally not authorized to be TRICARE providers in civilian facilities. Only TRICARE-certified civilian providers may receive reimbursement from TRICARE.

### Military Treatment Facilities (MTF)

An MTF is a medical facility (e.g., hospital, clinic) owned and operated by the uniformed services—usually located on or near a military base. To locate MTFs in the West Region, visit the MTF Locator at [www.tricare.mil/mtf](http://www.tricare.mil/mtf).



**Military Treatment Facility Right of First Refusal (ROFR)**

Provided the MTF is able to render the service requested, MTFs are given the ROFR for TRICARE Prime beneficiaries residing in a TRICARE Prime Service Area (PSA) for inpatient admission referrals, specialty appointments, and procedures requiring prior authorization. The MTF staff will review the referral to determine if they have the specialty capability and an available specialty care appointment within TRICARE access standards. If the MTF accepts the care, the beneficiary must obtain these services at the MTF. If the service is not available at the MTF within the appropriate access standards, the beneficiary is referred to a TRICARE network provider.

**TRICARE Provider Types**

**Figure 2.3**

TRICARE-Authorized Providers		
<ul style="list-style-type: none"> <li>• TRICARE-authorized providers meet state licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (<i>laboratory and radiology providers</i>), and pharmacies. Beneficiaries are responsible for the full cost of care if they see providers who are not TRICARE-authorized.</li> <li>• There are 2 types of TRICARE-authorized providers: <b>network</b> and <b>non-network</b>.</li> </ul>		
Network Providers	Non-Network Providers	
<ul style="list-style-type: none"> <li>• Regional contractors have established networks, even in areas far from military treatment facilities</li> <li>• TRICARE network providers:                             <ul style="list-style-type: none"> <li>› Have signed agreements with UnitedHealthcare to provide care</li> <li>› Agree to file claims and handle other paperwork for TRICARE beneficiaries</li> <li>› Are required to have malpractice insurance</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Non-network providers do not have signed agreements with UnitedHealthcare and, therefore, are considered “out of network.”</li> <li>• There are 2 types of non-network providers: <b>participating</b> and <b>nonparticipating</b>.</li> </ul>	
	Participating	Nonparticipating
	<ul style="list-style-type: none"> <li>• May choose to participate on a claim-by-claim basis</li> <li>• Agree to accept payment directly from TRICARE and accept the TRICARE-allowable charge as payment in full for their services</li> </ul>	<ul style="list-style-type: none"> <li>• Do not agree to accept the TRICARE-allowable charge or file claims for TRICARE beneficiaries</li> <li>• Have the legal right to charge beneficiaries up to 15% above the TRICARE-allowable charge for services</li> </ul>

Note: ROFR does not apply to TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPR ADFMs) enrollees seeking care at MTFs.

**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 rehabilitation clinics
- Comprehensive outpatient rehabilitation facilities
- Diabetic outpatient self-management education programs (American Diabetes Association® recognition required)
- Freestanding bone-marrow transplant centers
- Freestanding kidney-dialysis centers
- Freestanding magnetic resonance imaging centers
- Freestanding radiology centers
- Freestanding sleep disorder diagnostic centers
- Home health agencies
- Home infusion (Accreditation Commission for Health Care accreditation required)
- Independent physiological laboratories
- Pain-management clinics

- Rehabilitation clinics
- Radiation-therapy programs

Network corporate services providers are certified during the credentialing process. Non-network corporate services providers must apply to become TRICARE-authorized. Qualified non-network providers may download the *Application Form For Corporate Services Providers* by visiting [uhcmilitarywest.com](http://uhcmilitarywest.com) → Beneficiary → Find A Form → Certification.

## **The Department of Veterans Affairs (VA)**

TRICARE network provider information is given to the VA and to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). VA has the right to directly contact a provider and request care on a case-by-case basis for VA patients or CHAMPVA beneficiaries if the provider is available.

## **Provider Certification and Credentialing**

### **Certification**

At a minimum, TRICARE providers must be certified. PGBA conducts the certification process, which includes assigning a TRICARE ID number to the provider. Being TRICARE-certified allows accurate 1099 tax form reporting to the IRS. Providers who are only certified are considered non-network providers. Refer to [uhcmilitarywest.com](http://uhcmilitarywest.com) for information on how to become certified. Behavioral health care providers, skilled nursing facilities, providers in Alaska, and providers who are not Medicare-certified must complete and submit certification forms in order for PGBA to process their claims. To download certification forms, visit [mytricare.com](http://mytricare.com) → Providers → Forms → Provider Certification Forms.

### **Credentialing**

In addition to becoming certified, providers interested in signing a contract and becoming a member of the TRICARE network shall be credentialed by UnitedHealthcare. The credentialing process involves obtaining primary-source verification of the provider's education, board certification, license, professional background, malpractice history, and other pertinent data. A provider who is certified, credentialed, and has signed a contract is considered to be a network provider once informed of the final notification of contract execution by UnitedHealthcare.

Note: It is important that providers wait for final notification of contract execution from UnitedHealthcare before providing care to TRICARE beneficiaries as network providers.

## **Conflict of Interest**

Please note that federal law (5 U.S.C. 5536) prohibits medical personnel who are ADSMs or civilian employees of the government to receive compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary.

Claims for TRICARE benefits will be denied in any situation where either a uniformed service member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selection basis.

This means that MTF providers and providers who are activated National Guard and Reserve members may not self refer from an MTF or a federal government clinic to a civilian practice. Additionally, they may not bill TRICARE for services provided to any TRICARE beneficiary. For providers who are National Guard and Reserve members, this is effective only when the provider is activated, not when they receive their orders.

When a National Guard and Reserve member who is a network provider is activated, he or she may remain a network provider. However, during the activation period, the provider's information will not be displayed in the online TRICARE Provider Directory and in the referral and authorization system until the provider returns to civilian status. It is very important that the provider notifies UnitedHealthcare once he or she receives orders and upon return.

For more information, please contact the UnitedHealthcare Provider Service Line.

## **Provider Responsibilities**

When a provider signs a TRICARE Provider Agreement, the provider agrees to adhere to all contract requirements, as well as all applicable TRICARE program requirements. The following is a sample of network provider requirements, some which may be more fully detailed in the provider's contract:

- Provider agrees to accept the reimbursement rates (less the amount of any copayments, cost-shares, or deductibles payable by the TRICARE beneficiary) as the only payment expected from UnitedHealthcare and TRICARE beneficiaries for covered services and for all services paid for by the TRICARE program.
- Provider agrees to collect applicable copayments, cost-shares, or deductibles from TRICARE beneficiaries. Provider agrees not to require payment from a TRICARE beneficiary for any excluded or excludable service the TRICARE beneficiary received unless the TRICARE beneficiary has been properly informed that the services are excludable and has agreed, in writing, in advance of receiving the services, to pay for such services. Any waivers must be specific as to the details of the excluded or non-covered service. See "[Waiver of Non-Covered Services](#)" later in this section.
- Providers agree not to charge a beneficiary for the following:
  - › Services for which the provider is entitled to payment from TRICARE;
  - › Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;
  - › Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity;
  - › Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and
  - › Services rendered during a period in which the provider was not in compliance with one or more conditions of authorization.
- Provider agrees to submit all claims for covered services on behalf of TRICARE beneficiaries and ADSMs.
- Provider must participate in Medicare (accept assignment) and submit claims on behalf of all TRICARE and Medicare beneficiaries.
- Provider agrees to comply with all policies and procedures set forth in this Handbook and in the TRICARE manuals, including, without limitation, credentialing, peer review, referrals, utilization review/management, and quality-assurance programs and procedures established by UnitedHealthcare or TRICARE, including submission of information concerning provider and compliance with referral and authorization requirements, concurrent reviews, retrospective reviews, and discharge planning for inpatient admissions.
- Provider understands that the preferred method of submitting referral and authorization requests is by fax.
- If a provider delivers behavioral health care services, and the TRICARE beneficiary authorizes release of the information, the provider should submit a copy of the record of the treatment provided to the TRICARE beneficiary's primary care manager (PCM).

- Provider and staff will participate in TRICARE education programs to obtain an understanding of TRICARE requirements.
- Provider understands and agrees that all covered services provided to TRICARE Prime beneficiaries, except emergency services, clinical preventive services, and the first 8 outpatient behavioral health care visits for covered benefits from a network provider per fiscal year (FY, October 1–September 30), must be referred from the PCM to a network provider or an MTF provider, and authorized by the applicable designee of UnitedHealthcare.
- Provider acknowledges and understands the MTF has the ROFR to provide medical services to TRICARE Prime beneficiaries who are referred for any services by their PCMs or other civilian providers.
- Provider agrees to comply with all final HIPAA ASC X12N Transactions and Code Sets standards as promulgated by the secretary of HHS.
- Provider will include his or her NPI when submitting claims for health care services.
- Provider will furnish medical records and other documentation in accordance with applicable provisions of the Handbook, UnitedHealthcare’s utilization management plan or other policies, the provider’s contract, and TRICARE requirements. (For example: Specialists and facilities must submit consultation reports, discharge summaries, operative reports, therapy reports, or imaging studies to the beneficiary’s PCM within 10 working days. If clinically warranted, reports regarding additional procedures or skilled therapies conducted during follow-up visits should also be forwarded. A final report is required to the referring provider within 10 business days after the last visit. Refer to “Consult Report Tracking” in the *Health Care Management and Administration* section of this Handbook for additional information.)
- Provider agrees to submit at least one email address to UnitedHealthcare for purposes of communicating important TRICARE updates.
- Provider’s liability insurance must be, at a minimum, of the types and in the amounts set forth in the applicable *Liability Insurance Requirements Table*. Such insurance may be provided on either an occurrence basis or claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail) for a period of not less than 3 years after the end of the contract term with UnitedHealthcare must also be provided, or as long as standard practice in the locality or as may be required by local law or ordinance.
- Provider agrees to indemnify, defend and hold harmless the United States Government from any and all claims, judgments, costs, liabilities, damages and expenses, including attorneys’ fees, arising from any acts or omissions of the provider.
- Provider agrees to accept the negotiated payment rates for any person whose care is reimbursable by the Department of Defense.
- Provider agrees to cooperate fully with UnitedHealthcare’s utilization and clinical quality management programs.
- Provider agrees to refer TRICARE beneficiaries only to providers with which the referring provider does not have an economic interest (as defined in 32 C.F.R. 199.2).
- Provider agrees to limit services furnished under arrangement to those for which receipt of payment by the TRICARE authorized provider discharges the payment liability of the beneficiary.
- Provider agrees to being reported to the Department of Veterans Affairs (VA) as a TRICARE network provider. With regard to non-institutional network providers, the provider is asked to accept requests from the VA to provide care to veterans. The VA has the right to directly contact a provider and request the delivery of care to veteran patients on a case by case basis. An individual, home health care, free-

standing laboratory, and free-standing radiology network provider who accepts VA patients is required to serve as a participating provider and accept assignment with the VA. If seen by the network provider, any documentation of the care rendered to the VA patient and reimbursement for the care is a matter between the referring VA Medical Center (VAMC) and the provider. The referral and instructions for seeking reimbursement from the VAMC will be provided by the patient at the time of the appointment. Nothing prevents the VA and the provider from establishing a direct contract relationship if the parties so desire.

- Provider agrees to being reported to Civilian Health and Medical Program of the Department of Veteran's Administration (CHAMPVA) as a TRICARE network provider. An individual, home health care, free-standing laboratory, and free-standing radiology network provider who accepts CHAMPVA patients is required to serve as a participating provider and accept assignment with the VA. UnitedHealthcare will provide you with CHAMPVA claims processing instructions on submitting CHAMPVA claims to the VA Health Administration Center for payment.
- All acute-care medical/surgical hospitals in UnitedHealthcare's TRICARE network are encouraged to become members of the National Disaster Medical System.
- Provider agrees to give prompt written notification of the provider's employment of an individual who, at any time during the 12 months preceding, was employed in a managerial, accounting, auditing, or similar capacity, by an agency or organization which is responsible, directly or indirectly for decisions regarding Department of Defense (DoD) payments to the provider.

### **Non-Discrimination Policy**

When providing covered services, TRICARE network (contracted) and non-network providers agree not to discriminate against any TRICARE beneficiary or ADSM on the basis of his or her race, color, national origin, or any other bases recognized in applicable laws or regulations. Providers may read the full TRICARE Non-Discrimination policy by accessing the *TRICARE Operations Manual*, Chapter 1, Section 5 on the TRICARE website at <http://manuals.tricare.osd.mil>.

### **Office and Appointment Access Standards**

By signing a TRICARE contract, network providers are obligated to adhere to all contract requirements. One of the contract requirements is to meet all office and appointment access standards. Those standards are as follows:

- Office wait times for nonemergencies may not exceed 30 minutes, unless the provider is rendering emergency care and the normal schedule is disrupted. If you are running behind schedule, notify your patient of the cause and anticipated length of the delay, and offer to reschedule the appointment.
- PCM/primary care providers must be available by telephone or by appointment 24 hours a day, 7 days a week to provide timely evaluation of the beneficiary's health care needs. If the PCM/primary care provider is not available, the covering PCM/primary care provider is subject to UnitedHealthcare's credentialing and peer-review procedures.
- Wait times for appointments for acute illnesses may not exceed 1 day (24 hours).
- Wait times for routine appointments may not exceed 1 week (7 days).
- Wait times for appointments for wellness and specialty visits may not exceed 4 weeks (28 days).
- Wait times for the initial urgent behavioral health care appointment with a behavioral health care provider shall generally not exceed 24 hours.
- Wait times for the initial routine behavioral health care appointment with a behavioral health care provider may not exceed 1 week.



- Facilities and offices must be accessible to persons with disabilities, in accordance with federal and state regulations.

### **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 clinic 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**

TRICARE Prime beneficiaries agree to seek all nonemergency services initially from their PCMs who they selected for primary care services at the time of enrollment. The PCM is an individual provider within a military or a civilian location.

Note: TRICARE Prime beneficiaries may not initially seek services from any provider except their PCM, unless they are:

- Using the point-of-service (POS) option
- Seeking emergency care
- Seeking clinical preventive services from a network provider
- Seeking the first 8 outpatient behavioral health care visits for covered benefits from a network provider per FY

Note: ADSMs must always have a referral for care outside of an MTF (unless it is an emergency), including all behavioral health care services.

If the ADSM has an assigned civilian PCM under TRICARE Prime or a PCM under TPR, all specialty referral and authorization guidelines must be followed.

The PCM's roles and responsibilities are as follows:

- Primary care services are typically, although not exclusively, provided by internal medicine physicians, family practitioners, pediatricians, general practitioners, obstetricians, gynecologists, physician assistants, or nurse practitioners to the extent consistent with governing state rules and regulations.
- The PCM is responsible for performing primary care services and managing all of the care of his or her TRICARE Prime patients. The PCM must render care for acute illness, minor accidents, and follow-up care for ongoing medical problems.
- When a provider signs a contractual agreement to become a PCM (only applicable in PSAs), the provider must follow TRICARE procedures and requirements for obtaining specialty referrals and prior authorizations for nonemergency inpatient and certain outpatient services. Claims submitted for services rendered without a required prior authorization are subject to a penalty based on the contracted rate.
- In the event that the assigned PCM cannot provide the full range of necessary primary care functions, the PCM must provide support for access to the necessary health care services, as well as any specialty requirements.
- PCMs are required to provide access to care 24 hours a day, 7 days a week, including after hours and urgent care services, or arrange for on-call coverage by another provider.

Note: The on-call provider must be certified and preferably should be a TRICARE network provider who is also credentialed. The PCM or on-call provider will determine the level of care needed:



- › Routine care—The PCM instructs the TRICARE Prime beneficiary to contact the PCM’s office on the next business day for an appointment.
  - › Urgent care—The PCM or on-call provider coordinates timely care for the TRICARE Prime beneficiary.
  - › The on-call physician must contact the PCM within 24 hours of an inpatient admission to support continuity of care.
- PCMs referring patients for specialty care may need to coordinate the referral with UnitedHealthcare.
  - When a PCM refers a TRICARE Prime beneficiary for specialty obstetric care, prior authorization must be obtained for both outpatient and inpatient services.
  - The PCM enrollment panel should remain open to TRICARE beneficiaries. However, UnitedHealthcare requests a 30-day advance, written notification if the PCM determines that it is necessary to close his or her panel for a period of time.

### **Emergency Care Responsibilities**

Providers are required to notify UnitedHealthcare within 24 hours of an emergency admission. For more information on this requirement, see “Inpatient Admission Notification” in the *Health Care Management and Administration* section of this Handbook. This notification also applies on weekends. UnitedHealthcare case managers or UnitedHealthcare clinical staff will review the information submitted to determine if authorization is necessary. Except in true emergencies, TRICARE Prime enrollees must have approval from their PCMs or UnitedHealthcare, or the care may be covered under the TRICARE POS option. Refer to the *Medical Coverage* section of this Handbook for more information on emergency and urgent care services.

### **Balance Billing**

Network providers may only bill TRICARE beneficiaries for applicable deductible, copayment, or cost-sharing amounts, but may not bill for charges that exceed contractually agreed upon payment rates. Because network providers have contractually agreed to adhere to these provisions, TRICARE beneficiaries will be referred first to a network provider. Any provider who is uncertain about the amount that may be billed to a TRICARE beneficiary may call UnitedHealthcare at (877) 988-WEST/(877) 988-9378. The beneficiary’s responsibility is reflected on the explanation of benefits (EOB), and the provider’s remittance advice. Non-network providers who accept assignment are limited to collecting the TRICARE-allowable charge. If the billed charge is less than the allowable charge, the billed charge becomes the allowable amount. The balance billing restriction applies only to services covered by TRICARE.

Non-network, nonparticipating providers may collect applicable deductibles and/or cost-shares and copayments and any outstanding amounts up to 15% above the TRICARE-allowable charge (shown on the EOB) from a non-Prime beneficiary. If the billed charge is less than the TRICARE-allowable charge, the billed charge is the allowable amount used to process the claim. The balance billing restriction applies only to services covered by TRICARE. TRICARE’s balance billing limit also applies when other health insurance (OHI) is involved. Providers may not bill beneficiaries for administrative expenses, including collection fees, to collect TRICARE amounts.

The billing restriction for nonparticipating providers is contained in Section 9011 of the Department of Defense Appropriations Act of 1993 (Public Law 102-396), and became effective on November 1, 1993. The billing limitation is the same as that used by Medicare. For the specific details of this law, refer to 32 CFR 199.14 (j) (1)(C). Non-compliance with these balance-billing requirements by any TRICARE provider may affect that provider’s TRICARE and/or Medicare status. Additional information is available at [www.tricare.mil](http://www.tricare.mil) and [uhcmilitarywest.com](http://uhcmilitarywest.com).

### ***Balance Billing and Other Health Insurance (OHI)***

Providers are limited to collecting the amount as described earlier under “Balance Billing,” regardless of the beneficiary’s OHI financial responsibility. When OHI is involved, the provider may not collect more than his or her billed charges from the primary payer and TRICARE combined. TRICARE will pay the beneficiary liability unless that amount is more than the TRICARE-allowable charge. For additional information on OHI calculations, refer to [uhcmilitarywest.com](http://uhcmilitarywest.com).

### **Informing Beneficiaries about Non-Covered Services**

As part of good business practices, providers need to notify TRICARE beneficiaries when a service is not covered. TRICARE has established a specific hold-harmless policy for network providers and recommends that non-network providers also follow a similar process for documenting beneficiary notification.

Network providers cannot bill beneficiaries for non-covered services unless the beneficiary has agreed in advance and in writing to pay for non-covered services. See “Hold-Harmless Policy for Network Providers” later in this section.

### ***Hold-Harmless Policy for Network Providers***

A network provider may not require payment from a TRICARE beneficiary for any non-covered services the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) except as follows:

- If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary, the provider may bill the beneficiary for services provided.
- If the beneficiary was informed that the services were non-covered and he or she agreed in advance to pay for the services, the provider may bill the beneficiary.

TRICARE beneficiaries must be properly informed in advance and in writing of specific services or procedures that are not covered under TRICARE before they are provided. If they choose to be financially responsible for the non-covered services, beneficiaries must sign a waiver agreeing to pay for non-covered services. See “Waiver of Non-Covered Services” later in this section for details.

An agreement to pay must be evidenced by written records, examples of which include:

- Provider notes demonstrating that, before receiving services, the beneficiary was informed that the services were non-covered and the beneficiary agreed to pay for them
- A statement or letter written by the beneficiary prior to receipt of the services, acknowledging the services were non-covered and agreeing to pay for them

However, if the network provider does not obtain a legal signed waiver before the non-covered services are provided, and the care is not authorized by UnitedHealthcare, the provider is expected to accept full financial liability for the cost of non-covered services rendered without authorization by UnitedHealthcare or the beneficiary’s written agreement to pay for non-covered services.

For the beneficiary to be considered fully informed, TRICARE regulations require that:

- The agreement is documented prior to the specific non-covered services being rendered
- The agreement is in writing
- The specific treatment and date(s), estimated cost of service, and billed amounts are documented

General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or not allowable.

A general statement of financial liability does not satisfy this requirement.

### **Waiver of Non-Covered Services**

A network provider may utilize the *TRICARE Beneficiary Liability Form (Waiver of Non-Covered Services)* when the beneficiary is properly informed, in advance, that TRICARE does not cover a particular service and he or she agrees in writing to be financially responsible. The *Waiver of Non-Covered Services* form is available online at [uhcmilitarywest.com](http://uhcmilitarywest.com) → Find a Form. This waiver may not be used for TRICARE services that are not payable for other than benefit reasons (e.g., ClaimCheck® edits, administrative expenses, the difference between the allowed amount and paid amount). Waivers of non-covered services must be in writing and include the following:

- Indication that the rendering provider is a network provider
- Reference to the specific non-covered service or procedure
- Notice that the service or procedure is not covered
- Written agreement to be financially responsible for non-covered services prior to receiving those services
- The beneficiary's signature
- The date signed

Providers must maintain copies of the waiver in their offices. See the [Medical Coverage](#) section of this Handbook for a summary of TRICARE-covered and non-covered services and benefits.

### **Hold-Harmless Policy for Non-Network Providers**

Although non-network providers are not obligated to use a TRICARE-specific form to document the payment agreement, it is important that non-network providers inform beneficiaries that they will be responsible for paying for non-covered services. A written document listing the specific service(s) and cost(s) of the non-covered services identifying this agreement is recommended.

### **“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 hospital admission. The complete signed document must be kept in the beneficiary's file. A new document is needed for each admission. If PGBA or UnitedHealthcare requests a copy of the beneficiary's medical record, a copy of this entire document, signed by the beneficiary, must be included in the file. “An Important Message from TRICARE” is located at [uhcmilitarywest.com](http://uhcmilitarywest.com) → Find a Form.

It is important that beneficiaries be given the correct document that lists contact information for UnitedHealthcare, the West Region contractor. Medicare's similar document or another TRICARE contractor's document cannot be substituted for TRICARE West Region beneficiaries.

### **Updating Provider Information**

It is important for providers to report any outdated or incorrect demographic information as soon as possible. This enables UnitedHealthcare to provide accurate information to TRICARE beneficiaries and your claims are appropriately paid and payments are mailed to the correct address.

The online TRICARE Provider Directory helps providers and beneficiaries easily find most network providers within the TRICARE West Region. Network providers are urged to go to the TRICARE Provider Directory on the UnitedHealthcare website to examine their listings and determine if their information is accurate. Go to [uhcmilitarywest.com](http://uhcmilitarywest.com), click on the “Provider Directory” tab, and follow the easy steps to find and check your information. If you find incorrect information, contact the Provider Service Line promptly at (877) 988-9378.

Non-network providers are not listed in the UnitedHealthcare online TRICARE Provider Directory, but should submit provider demographic updates (e.g., tax identification number, physical location and contact information, claims payment address) to PGBA by visiting [myTRICARE.com](http://myTRICARE.com) or fax to PGBA at (855) 831-7044.

Note: Not all TRICARE network providers are listed in the TRICARE Provider Directory. For example, emergency room physicians, urgent care physicians, and some other hospital-based providers may not be published in the directory.

## Beneficiary Expectations

According to the DoD, all TRICARE beneficiaries should expect the following:

**Get information:** Beneficiaries should expect 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 should expect a choice of health care providers that is sufficient to provide access to appropriate high-quality health care.

**Emergency care:** Beneficiaries should expect to access medically necessary and appropriate emergency health care services as is reasonably available when and where the need arises.

**Participate in treatment:** Beneficiaries should expect to receive and review information about the diagnosis, treatment, and progress of their conditions, and to participate fully in all decisions related to their health care, or if unable to do so for him or herself, to be represented by family members or other duly appointed representatives.

**Respect and nondiscrimination:** Beneficiaries should expect to receive considerate, respectful care from all members of the health care system without discrimination based on race, color, national origin, or any other basis recognized in applicable law or regulations.

**Confidentiality of health information:** Beneficiaries should expect to communicate with health care providers in confidence and to have the confidentiality of their health care information protected to the extent permitted by law. They also should expect to review, copy, and request amendments to their medical records.

**Complaints and appeals:** Beneficiaries should expect a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them.

## TRICARE Eligibility

TRICARE is available worldwide to eligible beneficiaries, including ADSMs and their family members, retired service members and their dependents, National Guard and Reserve members and their families, survivors, certain former spouses, and others, from any of the 7 uniformed services: U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, the Commissioned Corps of the U.S. Public Health Service, and the Commissioned Corps of the National Oceanic and Atmospheric Administration.

All beneficiaries must register in the Defense Enrollment Eligibility Reporting System (DEERS) to be eligible for TRICARE. Beneficiaries may verify their eligibility in DEERS by calling (800) 538-9552. Providers, if registered, may check patient eligibility on the secure UnitedHealthcare website at [uhcmilitarywest.com](http://uhcmilitarywest.com). Providers may not contact DEERS directly due to the Privacy Act of 1974 (Title 5, United States Code, Section 552a).

### How to Verify Eligibility

There are several ID and enrollment cards with which providers should be familiar in order to verify a patient's eligibility for TRICARE. Providers must confirm patients have valid uniformed services ID cards, Common Access Cards (CACs), or authorization letters of eligibility. Be sure to check expiration dates and make copies of both sides of ID cards for your files. See "Copying ID Cards" later in this section.

An ID card alone is not sufficient to prove eligibility. Providers must verify the actual eligibility of the card bearer by accessing the secure UnitedHealthcare website at [uhcmilitarywest.com](http://uhcmilitarywest.com) (once registered), or by calling

(877) 988-WEST/(877) 988-9378. When verifying eligibility, be sure to use the sponsor's SSN or DBN. UnitedHealthcare's secure website will allow verification with either an SSN or the first 9 digits of the DBN. Providers using EDI 270/271 can verify eligibility using an SSN or DBN. UnitedHealthcare's IVR system can verify the sponsor's SSN and the DBN. If you are verifying online, retain a printout of the eligibility verification screen for your files.

Note: The DoD is in the process of removing SSNs from ID cards. Refer to the "Social Security Number Reduction Plan" in the *Important Provider Information* section of this Handbook for more information.

## Identification Cards

### Common Access Card (CAC)

Most ADSMs and drilling National Guard and Reserve members now carry the CAC. The CAC is replacing the uniformed services ID card discussed later in this section. Although CACs are valid uniformed services ID cards, they do not, on their own, prove TRICARE eligibility. The card bearer's eligibility must be verified as described earlier in this section.

### Uniformed Services ID Card

The uniformed services ID card is credit-card sized and incorporates a digital photographic image of the bearer, bar codes containing pertinent machine-readable data, and printed identification and entitlement information. The beneficiary category determines the ID card's color:

- **Active duty family members (ADFM):** Uniformed Services Identification and Privilege Card (*DD Form 1173*)—tan
- **National Guard and Reserve family members:** DoD Guard and Reserve Family Member Identification Card (*DD Form 1173-1*)—red
- **Retirees:** United States Uniformed Services Identification Card (Retired) (*DD Form 2 [RET]*)—blue
- **Retiree dependents:** *DD Form 1173*—tan
- **Transitional Assistance Management Program (TAMP) beneficiaries:** DoD/Uniformed Services Identification and Privilege Card (*DD Form 2765*)—tan

These boxes on the ID card contain useful information for the provider and the beneficiary:

- **SSN, sponsor SSN (or last 4 digits of SSN), DBN, or sponsor DBN:** Providers should use the SSN or DBN when verifying the card bearer's TRICARE eligibility.
- **Expiration date:** Check the expiration date. It should read "INDEF" (i.e., indefinite) 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." If a beneficiary using TRICARE For Life (TFL) has an ID card that reads "NO" in this block, they are still eligible to use TFL if they have Medicare Part A and Medicare Part B coverage.

Note: Eligibility may also be verified by a valid photo ID of the dependent when accompanied by a copy of the sponsor's activation orders when activated for more than 30 consecutive days.

Beneficiaries under age 10 are not routinely issued ID cards, so the parent's proof of eligibility may serve as proof of eligibility for the child.



## **ID Cards for Family Members Age 75 and Older**

All eligible family members and survivors of deceased uniformed services members who are age 75 and older will be issued permanent ID cards. Prior to September 2005, only retired uniformed services members were issued permanent ID cards.

## **Copying ID Cards**

Military personnel and their family members may express concern about having their uniformed services ID cards photocopied, perhaps because they have always been instructed never to lose or allow someone to use their cards. These instructions are designed to prevent identity theft and safeguard against someone impersonating U.S. military personnel and compromising security.

Although some TRICARE beneficiaries may believe that it is illegal to copy ID cards, it is, in fact, legal to copy uniformed services ID cards for authorized purposes.\* The legitimate cardholder may allow his or her military or uniformed services ID card to be photocopied to facilitate medical care eligibility determination and documentation, check cashing, or the administration of other military-related benefits. It is both allowable and advisable for providers to copy a beneficiary's ID card to facilitate eligibility verification and for the purpose of rendering needed health care services. DoD recommends that providers copy both sides of the ID cards and retain copies for future reference.

## **Important Notes about Eligibility**

ADFM's lose TRICARE eligibility at midnight on the day the active duty sponsor is separated from service, unless they are eligible for other TRICARE coverage, TAMP, Continued Health Care Benefit Program (CHCBP) coverage, or the sponsor is transitioning to retired status. Refer to the *TRICARE Program Options* section of this Handbook for more information on these programs.

ADSM's are required to be enrolled in TRICARE Prime; however, TRICARE Prime enrollment is not the criteria for treating an ADSM. ADSM's get care at MTF's.

If civilian network care is required, the MTF will provide a referral. The Military Medical Support Office (MMSO) will coordinate care in certain circumstances. Once a member's eligibility has been verified (as described previously in this section), care may be delivered and billed for payment.

## **Military Medical Support Office (MMSO)**

The MMSO is responsible for coordination and management of civilian emergency or referred health care required by active duty Army, Navy, Air Force, Marine Corps, Coast Guard, and certain TRICARE-eligible National Guard and Reserve members. Contact the MMSO for more information.

Military Medical Support Office  
P.O. Box 886999  
Great Lakes, IL 60088-6999  
(888) MHS-MMSO/(888) 647-6676  
[www.tricare.mil/mmso](http://www.tricare.mil/mmso)

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\* Title 18, United States Code, Section 701 prohibits photographing or possessing uniformed services ID cards in an unauthorized manner. Unauthorized use would exist only 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.



ADSM claims must be submitted to PGBA for processing as described in the *Claims Processing and Billing Information* section of this Handbook.

Note: National Guard and Reserve members seeking medical care for line-of-duty injuries may appear as ineligible in DEERS if they are activated for 30 or fewer days. Refer to “Line-of-Duty Care for National Guard and Reserve Members” in the *TRICARE Program Options* section of this Handbook for more information.

## **Entitlement to Medicare and TRICARE**

TFL is the Medicare-wrap-around coverage available to all TRICARE beneficiaries, regardless of age and place of residence, provided they have Medicare Part A and Medicare Part B, except as described below. Beneficiaries are eligible for TFL on the date they have both Medicare Part A and Medicare Part B.

However, the following beneficiaries, entitled to Medicare Part A, are not required to have Medicare Part B to remain TRICARE eligible.

- ADFMs remain eligible for TRICARE Prime and TRICARE Standard and TRICARE Extra options while the sponsor is on active duty. However, once the sponsor retires from active duty, the sponsor and his or her family members who are entitled to premium-free Medicare Part A must also have Medicare Part B to keep their TRICARE benefits.
- TRICARE Reserve Select, TRICARE Retired Reserve, CHCBP, and US Family Health Plan beneficiaries are not required to have Medicare Part B to remain covered under these programs.

Note: TRICARE advises beneficiaries to sign up for Medicare Part B when first eligible to avoid a break in TRICARE coverage. Beneficiaries who sign up later may have to pay a premium surcharge for as long as they have Part B. The Medicare Part B surcharge is 10% for each 12-month period that a beneficiary was eligible to enroll in Part B but did not enroll.

After turning 65, beneficiaries who are not eligible for premium-free Medicare Part A on their own or their current, former, or deceased spouse's record may remain eligible for TRICARE Prime or TRICARE Standard and TRICARE Extra. They must take the “Notice of Award” and/or “Notice of Disapproved Claim” they receive from the Social Security Administration (SSA) to the nearest ID card-issuing facility to update DEERS and get new ID cards.

Beneficiaries who receive disability benefits from the SSA are entitled to Medicare in the 25th month of receiving disability payments. The Centers for Medicare and Medicaid Services notifies beneficiaries of their Medicare entitlement date. If a beneficiary returns to work and his or her Social Security disability payments are suspended, his or her Medicare entitlement continues for up to 8 years and 6 months. When disability payments are suspended, beneficiaries receive a bill every 3 months for Medicare Part B premiums, and must continue to pay Medicare Part B premiums to remain eligible for TRICARE coverage.

## **Eligibility for TRICARE and Veterans Affairs Benefits**

In some cases, beneficiaries are eligible for benefits under both the TRICARE and VA programs. 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 covers beneficiaries even if they received treatment through VA for the same medical condition in a previous episode of care. However, TRICARE will not duplicate payments made by, or authorized to be made by, VA for treatment of a service-connected disability.

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

## **Veterans Affairs Benefits as OHI**

If beneficiaries are entitled to VA benefits, they may choose whether they see a TRICARE or VA provider. If they are not Medicare-eligible, VA coverage is considered OHI and TRICARE pays second to any out-of-pocket costs for VA services.

If beneficiaries are entitled to Medicare Part A due to age or another reason, they are considered Medicare-eligible, and generally must have Medicare Part B to keep the TRICARE benefit.\* TRICARE beneficiaries with Medicare Part A and Part B are covered by TFL, TRICARE's Medicare-wrap-around coverage. Under TFL, Medicare acts as the primary insurance and TRICARE acts as the secondary payer. VA care is not covered by Medicare, so if a beneficiary seeks care from a VA provider while using the TRICARE benefit, TFL pays first and Medicare pays nothing. In this situation, the beneficiary pays the TRICARE Standard fiscal year (October 1–September 30) deductible, cost-shares, and remaining billed charges. Alternatively, beneficiaries may choose to use the VA benefit when seeing VA providers. To minimize out-of-pocket costs once covered by TFL, beneficiaries should seek care from providers who participate in both TRICARE and Medicare.

## **TRICARE Program Options**

TRICARE offers comprehensive medical benefits to all TRICARE beneficiaries, as well as pharmacy and dental benefits. Depending on beneficiary category and location, they may be eligible for different program options. This section provides information on TRICARE program options, including the TRICARE Pharmacy Program, TRICARE Dental Program, and TRICARE Retiree Dental Program.

### **TRICARE Prime**

TRICARE Prime is a managed care option offered in TRICARE Prime Service Areas (PSAs). PSAs are generally located near a MTF, but may also be located in regions with high numbers of beneficiaries who are not necessarily near MTFs. TRICARE Prime enrollees receive most of their care from an assigned primary care manager (PCM). Wherever possible, a PCM located at an MTF is assigned, but a TRICARE network PCM may be assigned or selected if a MTF PCM is not available. The PCM provides and coordinates care, maintains patient medical records, and refers patients to specialists, if necessary. Specialty care referred by the PCM must be approved in advance by UnitedHealthcare. Most primary care is provided by the assigned PCM unless the PCM issues a referral.

### **Eligibility for TRICARE Prime**

TRICARE Prime is available to ADSMs and their families, retired service members and their dependents, eligible former spouses, and survivors under age 65, as well as certain individuals age 65 or older who are not entitled to premium-free Medicare Part A.

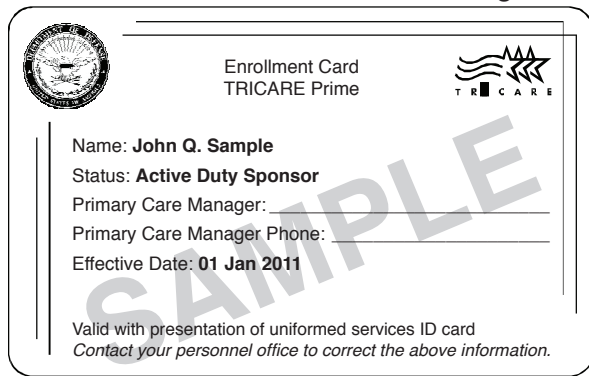
National Guard and Reserve members and their families may be eligible for TRICARE Prime in certain circumstances. See the [TRICARE Eligibility](#) section of this Handbook for instructions on how to verify patient eligibility.

### **TRICARE Prime Enrollment Card**

Beneficiaries enrolled in TRICARE Prime receive TRICARE Prime enrollment cards. These cards are not required to obtain care, but do contain important information for the beneficiary. An example of the TRICARE Prime enrollment card is shown in Figure 4.1.

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\* Certain beneficiaries may not need Medicare Part B to keep their TRICARE benefit. For more information, visit [www.tricare.mil/tfl](http://www.tricare.mil/tfl).



In addition to their TRICARE Prime enrollment cards, TRICARE Prime beneficiaries must present their uniformed services identification (ID) cards or CACs at the time of service. Only the uniformed services ID or CAC may be used to verify eligibility for care. Providers must verify eligibility at [uhcmilitarywest.com](http://uhcmilitarywest.com), if registered, or by calling (877) 988-WEST/(877) 988-9378. Eligibility is also verified as part of the prior authorization process. See the [TRICARE Eligibility](#) section of this Handbook for more information about verifying eligibility.

### Primary Care Manager

TRICARE Prime enrollees are assigned or select PCMs who provide and coordinate care, maintain patient medical records, and refer patients to specialists, if necessary. According to TRICARE, a provider who is practicing within the governing state's rules and regulations may be a PCM when rendering services within a TRICARE PSA. This includes the following PCM types:

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

A TRICARE Prime beneficiary relies on his or her PCM for referrals to specialty care providers and services either at MTFs or within the local network. For these services to be covered by TRICARE, the network PCM must submit a referral request to UnitedHealthcare.

Note: ADSMs always need referrals and prior authorizations for care outside of MTFs.

Providers should submit their requests by fax. Refer to [uhcmilitarywest.com](http://uhcmilitarywest.com) and the [Health Care Management and Administration](#) section of this Handbook for additional information. There is no requirement for a PCM referral and/or authorization for the following services:

- Those provided by the selected, assigned, or on-call PCM in his or her office
- The first 8 visits for outpatient behavioral health care services provided by a network provider in a fiscal year (FY, October 1– September 30) for medically necessary treatment for covered conditions by network providers who are authorized under TRICARE regulations to see patients independently.

Note: There are some provider types who require physician referrals and supervision. Refer to the *Behavioral Health Care Services* section of this Handbook for additional details. (After the initial 8 outpatient behavioral health care visits, prior authorization and medical necessity reviews are required.)

- Emergency care
- Clinical preventive services from a TRICARE network provider\*
- Services received while the beneficiary was using the POS option

See the *Important Provider Information* section of this Handbook for descriptions of specific PCM roles and responsibilities. TRICARE Prime beneficiaries must receive referrals from their PCMs or UnitedHealthcare for urgent care. If they do not receive referrals, the claims will be paid under the POS option.

UnitedHealthcare will assist with finding specialty care after a referral is requested. TRICARE Prime beneficiaries and retired service members with combat-related disabilities (regardless of program option) may be reimbursed for reasonable travel expenses for medically necessary care if UnitedHealthcare authorizes referrals to specialists located more than 100 miles away from their PCM's office.

For more information on reimbursement of travel expenses for specialty care, refer to the *TRICARE Reimbursement Manual*, Chapter 1, Section 30 at <http://manuals.tricare.osd.mil>.

TRICARE Prime enrollees are required to obtain all care from their PCMs unless referred to another TRICARE-authorized provider. Beneficiaries will be referred to a TRICARE network provider based on availability per the TRICARE access standards. A referral to a non-network TRICARE-authorized provider will only occur if a TRICARE network provider is not available. Refer to the *Health Care Management and Administration* section of this Handbook for more information about referrals and authorizations.

### **TRICARE Prime Point-of-Service Option (POS)**

A TRICARE Prime beneficiary who uses the POS option may self-refer to any TRICARE-authorized (network or non-network) provider for medical or surgical services. For behavioral health services, the POS option applies when the TRICARE Prime beneficiary receives non-emergency services from a non-network provider. Although a referral is not required when using the POS option, certain prior authorization requirements still apply.

When using the POS option, the beneficiary will pay a deductible and 50% of the TRICARE-allowable charge. These costs do not accrue toward the beneficiary's catastrophic cap. However, special considerations apply if the beneficiary has OHI.

The POS option does not affect the provider's reimbursement, but the beneficiary will pay a larger portion of the TRICARE-allowable charge. To help beneficiaries avoid using the POS option, providers should make sure to note the end date of referrals and to advise beneficiaries when additional referrals are required.

Note: ADSMs may not use the POS option. ADSMs always need referrals to receive care outside of MTFs.

### **Tips to Avoid Unnecessary Point-of-Service Costs**

The PCM should provide urgent (non-emergency) care. If the care is being provided because the PCM's office is closed or because the patient is out of area, the patient should call (877) 988-WEST/(877) 988-9378 as soon as practical to notify UnitedHealthcare that the care has been rendered.

If additional labs, x-rays, and minor procedures are required as part of an authorized episode of care, please review the Prior Authorization List at [uhcmilitarywest.com](http://uhcmilitarywest.com) and fax the request, when needed, for the additional services.

Preventive services may also be provided without referrals, except to ADSMs, when performed by network providers. For a listing of preventive benefits, refer to the *Medical Coverage* section of this Handbook.

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\* Excludes ADSMs, who always need referrals to receive care outside of MTFs.

## TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM)

TPR and TPRADFM provide TRICARE Prime coverage to ADSMs (including activated National Guard and Reserve members) and their families in remote locations through a civilian network of TRICARE-authorized providers, institutions, and suppliers (network or non-network).

ADSMs and their families who live and work more than 50 miles or a one-hour drive time from an MTF designated as adequate to provide primary care may be eligible to enroll in TPR or TPRADFM. To determine if a particular ZIP code falls within a TPR coverage area, use the ZIP code lookup tool at [www.tricare.mil/tpr/](http://www.tricare.mil/tpr/).

National Guard and Reserve members and their families may be eligible for TPR and TPRADFM in certain circumstances. See the *TRICARE Eligibility* section of this Handbook for instructions on how to verify patient eligibility.

### Accessing Health Care

TPR and/or TPRADFM beneficiaries select assigned primary care providers to provide primary care services and coordinate specialty care. If there are no network providers in their areas, TPR and TPRADFM beneficiaries may have to choose non-network TRICARE-authorized providers. These beneficiaries may also receive services from military providers if they are willing to travel to MTFs.

ADSMs receive primary care services from their primary care provider without referrals, prior authorizations, or fitness-for-duty reviews. Specialty and inpatient care require referrals and prior authorizations from UnitedHealthcare and the service point of contact (SPOC). ADSMs who do not have primary care providers must coordinate requests for specialty care through UnitedHealthcare and the SPOC. The SPOC will determine how to manage referrals if care is related to fitness for duty.

TPRADFM beneficiaries may require referrals for specialty care and/or prior authorizations for certain services. Providers should fax requests for TPR and TPRADFM referral and authorization requests. Refer to the *Health Care Management and Administration* section of this Handbook or visit [uhcmilitarywest.com](http://uhcmilitarywest.com) → Referrals and Authorizations for more information.

### TPR and TPRADFM Enrollment Cards

Beneficiaries enrolled in TPR and TPRADFM receive TPR enrollment cards. These cards are not required to obtain care, but do contain important information for the beneficiary. Figure 4.2 on the following page shows an example of the TPR enrollment card. Figure 4.3 on the following page shows an example of the TPRADFM enrollment card.

**TPR Enrollment Card**

**Figure 4.2**

The image shows a sample TRICARE Prime Remote Enrollment Card. It features the Department of Defense seal on the left and the TRICARE logo on the right. The card contains the following information:

- Enrollment Card  
TRICARE Prime Remote
- Name: **John Q. Sample**
- Status: **Active Duty Sponsor**
- Primary Care Manager: \_\_\_\_\_
- Primary Care Manager Phone: \_\_\_\_\_
- Effective Date: **01 Jan 2011**

At the bottom, it states: "Valid with presentation of uniformed services ID card. Contact your personnel office to correct the above information." A large "SAMPLE" watermark is overlaid diagonally across the card.



Enrollment Card TRICARE  
Prime Remote for Active  
Duty Family Members

Name: **John Q. Sample**  
Status: **Active Duty Family Member**  
Primary Care Manager: \_\_\_\_\_  
Primary Care Manager Phone: \_\_\_\_\_  
Effective Date: **01 Jan 2011**

Valid with presentation of uniformed services ID card  
Contact your personnel office to correct the above information.

In addition to their TPR enrollment cards, beneficiaries must present their uniformed services ID cards or CACs at the time of service. Only the uniformed services ID or CAC may be used to verify eligibility for care. Providers must verify eligibility on [uhcmilitarywest.com](http://uhcmilitarywest.com) (once registered) or by calling (877) 988-WEST/(877) 988-9378. Eligibility is also verified as part of the prior authorization process. See the [TRICARE Eligibility](#) section of this Handbook for more information about verifying eligibility.

### TPR and TPRADFM Point-of-Service Option

The POS option does not apply to TPR ADSMs. If they receive care without referrals or prior authorizations, claims will be forwarded to the SPOC for payment determination. If the SPOC does not approve the care, the ADSM is responsible for the bill. If the SPOC approves the care, the ADSM does not have copayments, cost-shares, or deductibles. However, TPRADFM beneficiaries are subject to the same POS provisions as TRICARE Prime beneficiaries. They must coordinate care with their primary care providers, or they will be required to pay a deductible and a 50% cost-share.

### TRICARE Standard and TRICARE Extra

TRICARE Standard is a fee-for-service option that allows beneficiaries to seek care from any TRICARE-authorized non-network provider. TRICARE Extra is a preferred provider option that allows beneficiaries to reduce out-of-pocket costs by visiting TRICARE network providers. TRICARE Standard and TRICARE Extra are available to all TRICARE-eligible beneficiaries except ADSMs. Beneficiaries are responsible for FY deductibles and cost-shares. Beneficiaries may see any TRICARE-authorized provider they choose, and TRICARE will share the cost of covered services with the beneficiaries after deductibles are met.

For specific cost-shares, visit the TRICARE website at [www.tricare.mil/costs](http://www.tricare.mil/costs) or the UnitedHealthcare website at [uhcmilitarywest.com](http://uhcmilitarywest.com).

### TRICARE For Life (TFL)

TFL is TRICARE's Medicare-wrap-around coverage available worldwide to TRICARE beneficiaries regardless of age, provided they are entitled to premium-free Medicare Part A and also have Medicare Part B. TFL is available to all TRICARE and Medicare dual-eligible\* beneficiaries, including retired members of the National Guard and Reserve who receive retired pay, family members, survivors of deceased sponsors, and certain former spouses. Dependent parents and parents-in-law are not eligible for TFL, but may be eligible for space-available care at an MTF. TFL coverage is effective the first day that a TRICARE beneficiary's Medicare Part A and Part B are effective.

TFL beneficiaries have the freedom to seek care from any Medicare-participating, nonparticipating, or opt-out provider, at MTFs on a space-available basis, or at VA facilities (if eligible). Medicare cannot pay for services

\* The term "dual-eligible" refers to TRICARE and Medicare dual eligibility and should not be confused with Medicare-Medicaid "dual eligible."

received from VA. Therefore, TRICARE is the primary payer for VA claims and beneficiaries will be responsible for the TRICARE annual deductible and cost-shares. Alternatively, beneficiaries may choose to use their VA benefit.

Note: Neither TRICARE nor Medicare will reimburse costs not covered by VA. Providers who opt-out of Medicare are not permitted to bill Medicare.

Some beneficiaries entitled to premium-free Medicare Part A, including ADSMs, ADFMs, and beneficiaries with TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), and US Family Health Plan (USFHP), may keep their current TRICARE benefits without Medicare Part B coverage. Medicare allows certain beneficiaries, including ADSMs and ADFMs, 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 to avoid a break in TRICARE coverage and Medicare monthly late-enrollment premium surcharges.

Note: Beneficiaries age 65 and older who are not eligible for premium-free Medicare Part A may remain eligible for TRICARE Prime (if residing in PSAs) or TRICARE Standard and TRICARE Extra. Beneficiaries with only Medicare Part A or only Medicare Part B are not eligible for TFL. Medicare Part B coverage is recommended for TRICARE and Medicare dual-eligible beneficiaries enrolled in the USFHP,\*\* TRS, or TRR but it is not required. Refer to “Entitlement to Medicare and TRICARE” in the *TRICARE Eligibility* section of this Handbook for more information.

### **How to Identify TRICARE For Life Beneficiaries**

Each TFL beneficiary must present a valid uniformed services ID card, as well as a Medicare card, prior to receiving services. You should copy both sides of the cards and retain the copies for your files. There is no separate TFL enrollment card. To verify TFL eligibility, contact Wisconsin Physicians Service (WPS/TFL) at (866) 773-0404. You may call the SSA at (800) 772-1213 to confirm a patient’s Medicare status.

### **How TRICARE For Life Works**

The provider first files claims with Medicare. Medicare pays its portion and electronically forwards the claim to WPS/TFL. WPS/TFL sends its payment for TRICARE-covered services directly to the provider. Beneficiaries receive a *Medicare Summary Notice* from Medicare and a TFL explanation of benefits from WPS/TFL indicating the amounts paid.

- For services covered by both TRICARE and Medicare, Medicare pays first, then TRICARE pays its share of the remaining expenses (unless the beneficiary has OHI).
- For services covered by TRICARE but not by Medicare, such as care received overseas, Medicare pays nothing and TRICARE becomes the primary payer. The beneficiary is responsible for the TRICARE FY annual deductible and cost-shares.
- For services covered by Medicare but not by TRICARE, Medicare is the primary payer and TRICARE pays nothing. The beneficiary is responsible for the Medicare deductible and cost-shares.
- For services not covered by Medicare or TRICARE (e.g., cosmetic surgery), the beneficiary is responsible for the entire bill.

### **How TRICARE For Life Works with Other Health Insurance**

TRICARE and Medicare beneficiaries with OHI, such as a Medicare supplement or employer-sponsored health plan, may also use TFL. By law, TRICARE pays claims only after any OHI plans have paid. Typically, after

\* The special enrollment period does not apply to beneficiaries entitled to Medicare based on end-stage renal disease. These beneficiaries are encouraged to sign up for Medicare Part B when first eligible to avoid the Medicare Part B late-enrollment surcharge.

\*\* USFHP enrollees who develop end-stage renal disease must have Medicare Part B.

Medicare processes a claim, the claim is forwarded to the beneficiary's OHI. Once the OHI processes the claim, the beneficiary will need to file a paper claim with TRICARE for any out-of-pocket expenses.

### **TRICARE For Life Referrals and Authorizations**

Because Medicare is the primary payer, providers do not need to obtain referrals or prior authorization from UnitedHealthcare. However, dual-eligible beneficiaries may need authorization from UnitedHealthcare if Medicare benefits are exhausted, or for care covered by TRICARE but not Medicare. See the *Health Care Management and Administration* section of this Handbook for services requiring referrals or authorizations.

If you have questions about TFL, contact WPS/TFL at (866) 773-0404 or visit the WPS website at TRICARE4u.com.

See the *Claims Processing and Billing Information* section of this Handbook for information about filing TFL claims.

### **TRICARE for the National Guard and Reserve**

The 7 National Guard and Reserve components include:

- Army National Guard
- Army Reserve
- Marine Corps Reserve
- Navy Reserve
- Air Force Reserve
- Air National Guard
- 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 and Reserve member is in a duty status, either inactive duty (such as reserve drill) or active duty. This includes the time period when members are traveling directly to or from the place where they perform military duty. National Guard and Reserve members will receive written authorization that specifies the LOD condition and terms of coverage.

LOD coverage is separate from any other TRICARE coverage in effect, such as:

- Transitional health care coverage under the Transitional Assistance Management Program (TAMP) or Transitional Care for Service-Related Conditions (TCSRC)
- Coverage under the TRS program option

Services for LOD conditions are generally delivered at an MTF if there is one nearby that has the capability. The MTF may refer the National Guard or Reserve member to civilian TRICARE providers. If there is no MTF nearby to deliver or coordinate the care, the MMSO may coordinate nonemergency care through any TRICARE-authorized civilian provider.

If UnitedHealthcare receives an LOD claim that was not referred by an MTF or pre-approved by the MMSO, UnitedHealthcare will forward the claim to the MMSO for approval or denial. The provider should submit medical claims directly to PGBA, UnitedHealthcare's claims processor, unless otherwise specified on the LOD written authorization or requested by the National Guard or Reserve member's Medical Department Representative. Any claims for services submitted for a National Guard or Reserve member with an LOD condition must be directly related to the condition documented on the LOD written authorization.

If a claim is denied by the MMSO for eligibility reasons, the provider's office should bill the member. The MMSO may approve payment once the appropriate eligibility documentation is submitted. It is the National Guard or Reserve member's responsibility to ensure that appropriate eligibility documentation is submitted by the unit to the MMSO and that all follow-up care is authorized by the MMSO SPOC.

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

National Guard and Reserve members with activation orders for a period of more than 30 consecutive days in support of a contingency operation may be TRICARE-eligible for 180 days prior to mobilization and until either deactivation prior to mobilization, or until 180 days after deactivation post-mobilization. They are considered ADSMs during the active duty period when on orders. Service members should not enroll in TRICARE Prime or TPR during the early eligibility period, but must enroll (following command guidance and depending on location) when they reach their final duty stations.

Family members of these National Guard and Reserve members may also become eligible for TRICARE if the National Guard and Reserve member (sponsor) is called to active duty for more than 30 consecutive days. These family members may enroll in TRICARE Prime or TPRADFM, depending on location, or they may use TRICARE Standard and TRICARE Extra. They are also eligible for dental coverage through the TDP. Sponsors are required to register their family members in DEERS.

Providers must follow the program rules, benefits, costs, referral and prior authorization requirements, and billing guidelines for the particular program option the family chooses.

### **TRICARE Reserve Select (TRS)**

TRS is a premium-based health plan offered by DoD that provides comprehensive health care coverage to qualifying members of the Selected Reserve of the Ready Reserve.

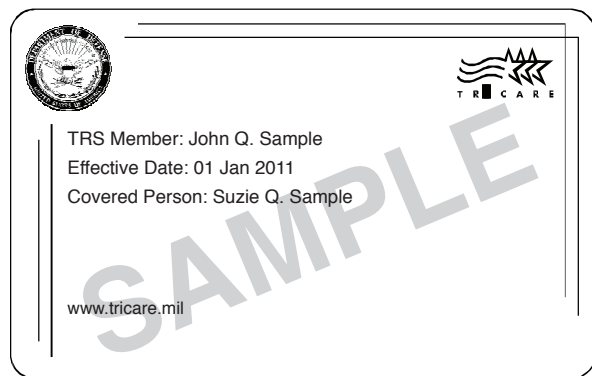
#### **Verifying TRICARE Reserve Select Coverage**

After purchasing TRS, each member and covered family member receives a TRS enrollment card. You should make a photocopy of the front and back of the card for your files. Providers must verify coverage status at [uhcmilitarywest.com](http://uhcmilitarywest.com), if registered for the secure website, or by contacting UnitedHealthcare at (877) 988-WEST/(877) 988-9378.

Figure 4.5 shows an example of the TRS enrollment card.

**TRS Enrollment Card**

**Figure 4.5**



#### **TRICARE Reserve Select Coverage**

TRS offers comprehensive coverage and patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra. TRS members may access care from any TRICARE-authorized provider, hospital,

or pharmacy—network or non-network—without a referral. TRICARE requires prior authorization for certain services. Refer to the UnitedHealthcare Prior Authorization List on [uhcmilitarywest.com](http://uhcmilitarywest.com) for services requiring prior authorization. TRS prior authorization requirements are the same as TRICARE Standard and TRICARE Extra. You may also visit [uhcmilitarywest.com](http://uhcmilitarywest.com) for additional information about submitting referrals and authorizations. See the *Health Care Management and Administration* section of this Handbook for more information.

### **Claims and Reimbursement**

See the *Claims Processing and Billing Information* section of this Handbook or visit [uhcmilitarywest.com](http://uhcmilitarywest.com) for details about filing TRS claims.

For more information, visit the TRS website at [www.tricare.mil/trs](http://www.tricare.mil/trs). You may also visit [uhcmilitarywest.com](http://uhcmilitarywest.com) for additional information about submitting claims.

### **TRICARE Retired Reserve (TRR)**

TRR is a premium-based health plan offered by the DoD that members of the Retired Reserve may qualify to purchase. TRR provides comprehensive health care coverage and patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra, but TRR beneficiaries must pay monthly premiums.

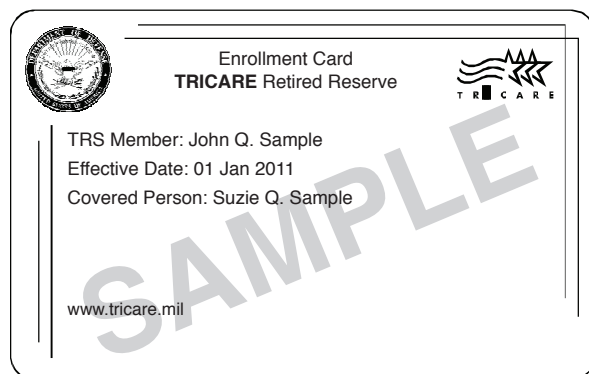
### **Verifying TRICARE Retired Reserve Coverage**

After purchasing either member-only or member-and-family TRR coverage, TRR members receive TRR enrollment cards. These cards include important contact information but are not required to obtain care. Although beneficiaries should expect to present their cards at the time of service, enrollment cards do not verify TRICARE eligibility. You should make a photocopy of the front and back of the card for your files. Secure website users should verify patient eligibility at [uhcmilitarywest.com](http://uhcmilitarywest.com). Otherwise you may call UnitedHealthcare at (877) 988-West/(877) 988-9378.

Figure 4.6 shows an example of the TRR enrollment card.

**TRR Enrollment Card**

**Figure 4.6**



### **TRICARE Retired Reserve Coverage**

TRR members may self-refer to any TRICARE-authorized provider; however, certain services (e.g., inpatient admissions for substance use disorders and behavioral health, adjunctive dental care, home health services) require prior authorization from UnitedHealthcare. Refer to the UnitedHealthcare Prior Authorization List at [uhcmilitarywest.com](http://uhcmilitarywest.com) for services requiring prior authorization. TRR prior authorization requirements are the same as TRICARE Standard and TRICARE Extra. See the *Health Care Management and Administration* section of this Handbook for more information about referral and authorization requirements.



## Claims and Reimbursement

See the *Claims Processing and Billing Information* section of this Handbook or visit [uhcmilitarywest.com](http://uhcmilitarywest.com) for details about filing TRR claims.

For more information, visit the TRR website at [www.tricare.mil/trr](http://www.tricare.mil/trr). You may also visit the Claims/Payments section of [uhcmilitarywest.com](http://uhcmilitarywest.com).

## TRICARE Young Adult (TYA)

The TYA program is a premium-based health care plan available for purchase by qualified dependents. Beneficiaries who are adult-age dependents may purchase TYA coverage based on the eligibility established by their uniformed service sponsor and where they live. TYA includes medical and pharmacy benefits, but excludes dental coverage.

Note: Special eligibility conditions may exist. Beneficiaries may purchase TYA coverage if they meet all of the following criteria:

- A dependent of an eligible uniformed service sponsor\*
- Unmarried
- At least age 21 (or age 23 if enrolled in a full-time course of study at an approved institution of higher learning and if the sponsor provides over 50% of the financial support), but have not yet reached age 26
- Not eligible to enroll in an employer-sponsored health plan as defined in TYA regulations
- Not otherwise eligible for TRICARE program coverage

For more information on TYA, visit [www.tricare.mil/tya](http://www.tricare.mil/tya).

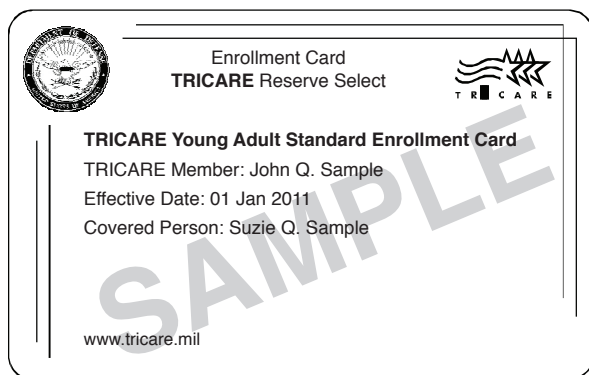
\* If the beneficiary is an adult child of a non-activated member of the Selected Reserve of the Ready Reserve or of the Retired Reserve, their sponsor must be enrolled in TRICARE Reserve Select or TRICARE Retired Reserve to be eligible to purchase TYA coverage.

## TYA Enrollment Card

Beneficiaries enrolled in TYA receive TYA enrollment cards. These cards are not required to obtain care, but do contain important information for the beneficiary. Figure 4.4 shows an example of the TYA enrollment card.

**TYA Enrollment Card**

**Figure 4.4**



In addition to their TYA enrollment cards, beneficiaries must present their uniformed services ID cards at the time of service. Only the uniformed services ID card may be used to verify eligibility for care. Providers must verify eligibility on [uhcmilitarywest.com](http://uhcmilitarywest.com) (once registered) or by calling (877) 988-WEST/(877) 988-9378. Eligibility is also verified as part of the prior authorization process. See the *TRICARE Eligibility* section of this Handbook for more information about verifying eligibility.

## TRICARE Pharmacy Program

TRICARE provides a world-class pharmacy benefit. TRICARE beneficiaries—including Medicare-eligible beneficiaries age 65 and older—are eligible for the TRICARE Pharmacy Program.

Note: Medicare-eligible beneficiaries who turned 65 after April 1, 2001, must enroll in Medicare Part B and confirm their DEERS profile is updated to use the TRICARE pharmacy benefit.

Eligible beneficiaries may use any of these options to have a written prescription filled:

- **MTF pharmacies:** Using an MTF pharmacy is the least expensive option, but formularies may vary by MTF pharmacy location. Contact the local MTF pharmacy to check availability before prescribing a medication.
- **TRICARE Pharmacy Home Delivery:** TRICARE Pharmacy Home Delivery (formerly TRICARE Mail Order Pharmacy) is the preferred method when not using an MTF pharmacy.
- **TRICARE retail network pharmacies:** Beneficiaries may access a network of approximately 60,000 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 to beneficiaries.

To have a prescription filled, beneficiaries will need a prescription and a valid uniformed services ID card. All prescriptions filled through TRICARE Pharmacy Home Delivery must have the prescriber's handwritten signature.

Note: USFHP participants may only use the pharmacy benefits provided under that program.

For more information on the TRICARE Pharmacy Program, visit [www.tricare.mil/pharmacy](http://www.tricare.mil/pharmacy) or [www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE) or call Express Scripts, Inc. (Express Scripts) at (877) 363-1303.

### Member Choice Center

TRICARE established the Member Choice Center (MCC) to help TRICARE beneficiaries transfer their retail pharmacy prescriptions to home delivery. Beneficiaries may call the MCC at (877) 363-1433 or access information online by visiting [www.tricare.mil/pharmacy](http://www.tricare.mil/pharmacy) or [www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE).

When TRICARE beneficiaries contact the MCC, an Express Scripts patient-care advocate will verify their information and walk them through the conversion process. To help facilitate the process, the patient-care advocate may contact you to have your patient's prescriptions transferred to TRICARE Pharmacy Home Delivery.

### 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 prior 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.

### Prior Authorizations

Some drugs require prior authorization from Express Scripts. Medications requiring prior authorization may include, but are not limited to, prescription drugs specified by the DoD Pharmacy and Therapeutics (P&T)

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\* Currently, there are no TRICARE retail network pharmacies in American Samoa.

Committee, brand-name medications with generic equivalents, medications with age limitations, and medications prescribed for quantities exceeding normal limits.

Visit [www.pec.ha.osd.mil/formulary\\_search.php](http://www.pec.ha.osd.mil/formulary_search.php) for a general list of TRICARE-covered prescription drugs that require prior authorization and to access prior authorization and medical necessity criteria forms for retail network and home delivery prescriptions. MTF pharmacies may follow different procedures. The top of each form contains information on where to send the completed form. For assistance, call Express Scripts at (877) 363-1303.

### **Uniform Formulary Drugs and Non-Formulary Drugs**

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 P&T Committee may recommend to the director of the TRICARE Management Activity that certain drugs be placed in the third, “non-formulary” tier. These medications include any drug in a therapeutic class determined to be not as relatively clinically effective or as cost-effective as other drugs in the same class.

For a higher copayment, 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 by completing and submitting the appropriate TRICARE Pharmacy Program medical necessity form to Express Scripts for the non-formulary medication. Visit [www.pec.ha.osd.mil/forms\\_criteria.php](http://www.pec.ha.osd.mil/forms_criteria.php) to download the form.

- **ADSMs:** If medical necessity is approved, ADSMs may receive non-formulary medications through TRICARE Pharmacy Home Delivery or at 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 at retail network pharmacies.

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 beneficiary experiences, or is likely to experience, significant adverse effects from the formulary alternative and the beneficiary is reasonably expected to tolerate the non-formulary medication.
- The formulary alternative results in therapeutic failure and the beneficiary is reasonably expected to respond to the non-formulary medication.
- The beneficiary previously responded to a non-formulary medication and changing to a formulary alternative would incur unacceptable clinical risk.
- There is no formulary alternative.

Call Express Scripts at (877) 363-1303 or visit [www.pec.ha.osd.mil/forms\\_criteria.php](http://www.pec.ha.osd.mil/forms_criteria.php) for forms and medical-necessity criteria. To learn more about medications and common drug interactions, check for generic equivalents, or determine if a drug is classified as a non-formulary medication, visit the online TRICARE Formulary Search Tool at [www.pec.ha.osd.mil/formulary\\_search.php](http://www.pec.ha.osd.mil/formulary_search.php).

### **Step Therapy**

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 (e.g., 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, see “Medications Identified by the DoD P&T Committee” at [www.tricare.mil/pharmacy/prior\\_auth.cfm](http://www.tricare.mil/pharmacy/prior_auth.cfm).

### **Medicare-Eligible Beneficiaries**

Medicare-eligible beneficiaries are able to use the TRICARE Pharmacy Program if they are eligible for Medicare Part A and enrolled in Medicare Part B. If they do not have Medicare Part B, they may only access pharmacy benefits at MTFs.\* Medicare-eligible beneficiaries are also eligible for Medicare Part D prescription drug plans. However, beneficiaries do not need to enroll in a Medicare Part D plan to keep their TRICARE Pharmacy Program benefits.

You may direct eligible beneficiaries who inquire about Medicare Part D coverage to visit [www.tricare.mil/medicarepartd](http://www.tricare.mil/medicarepartd). However, for the most up-to-date information on the Medicare Part D prescription drug benefit, beneficiaries should call Medicare at (800) MEDICARE/(800) 633-4227 or visit the Medicare website at [medicare.gov](http://medicare.gov).

### **Pharmacy Data Transaction Service (PDTS)**

The PDTS is a centralized data repository that records information about DoD beneficiaries' prescriptions. PDTS allows providers to access complete patient medication histories, helping to increase patient safety by reducing the likelihood of adverse drug interactions, therapeutic overlaps, and duplicate treatments. PDTS conducts an online prospective drug-utilization review (i.e. 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 TRICARE Pharmacy Home Delivery, MTF pharmacies, MTF providers, and TRICARE retail network pharmacies.

### **Specialty Medication Care Management**

Specialty medications are usually high-cost, self-administered, injectable, oral, or infused drugs that treat serious chronic conditions (e.g., multiple sclerosis, rheumatoid arthritis, hepatitis C). These drugs typically require special storage and handling and are not readily available at local pharmacies. Specialty medications may also have side effects that require pharmacist and/or nurse monitoring. The Specialty Medication Care Management program is structured to improve the beneficiary's health through continuous health evaluation, ongoing monitoring, assessment of educational needs, and management of medication use. This 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 consultation with a nurse or pharmacist at any point during therapy

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

These services are provided to beneficiaries at no additional cost when they receive their medications through TRICARE Pharmacy Home Delivery, and participation is voluntary. If you or your patient orders a specialty medication from TRICARE Pharmacy Home Delivery, Express Scripts sends the patient additional information about the Specialty Medication Care Management program and how to get started.

Beneficiaries enrolled in the Specialty Medication Care Management program have access to pharmacists 24 hours a day, 7 days a week. The specialty clinical team reaches out to the beneficiaries' physicians, as needed, to address beneficiary 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 prepopulated enrollment forms.

If a patient requires specialty pharmacy medications, you may fax the prescription to TRICARE Pharmacy Home Delivery at (877) 895-1900. TRICARE Pharmacy Home Delivery ships medications to the beneficiary's home. Faxed prescriptions must include the following ID 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, TRICARE Pharmacy Home Delivery 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, visit [www.pec.ha.osd.mil/formulary\\_search.php](http://www.pec.ha.osd.mil/formulary_search.php).

## **TRICARE Dental Options**

The TRICARE medical benefit covers adjunctive dental care (e.g., dental care that is medically necessary to treat a covered medical condition). Additionally, several non-adjunctive dental care options are available to eligible beneficiaries. ADSMs receive dental care at military dental treatment facilities (DTFs) or from civilian providers through the TRICARE Active Duty Dental Program (ADDP), if necessary. For all other beneficiaries, TRICARE offers 2 premium-based dental programs—the TRICARE Dental Program (TDP) or the TRICARE Retiree Dental Program (TRDP). Each program is administered by a separate dental contractor and has its own monthly premiums and cost-shares.

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 age 5 and younger. See the *Medical Coverage* section of this Handbook for more details.

### **TRICARE Active Duty Dental Program (ADDP)**

The ADDP is administered by United Concordia Companies, Inc. (United Concordia), and provides civilian dental care to ADSMs who are referred for care by a military DTF or who serve duty and reside greater than 50 miles from a DTF. Visit [www.addp-ucci.com](http://www.addp-ucci.com) or [www.tricare.mil/dental](http://www.tricare.mil/dental) for more information.

### **TRICARE Dental Program (TDP)**

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. 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 180 days prior to their report date) are not eligible for the TDP. They receive dental care at military DTFs or through the ADDP.

Visit [www.tricare.mil/dental](http://www.tricare.mil/dental) for more information.



## **TRICARE Retiree Dental Program (TRDP)**

The TRDP is a voluntary dental insurance program administered by Delta Dental® of California (Delta Dental). The TRDP offers comprehensive, cost-effective dental 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. For more information, visit the TRDP website at [trdp.org](http://trdp.org), or call Delta Dental toll-free at (888) 838-8737.

## **Cancer Clinical Trials**

The DoD Cancer Prevention and Treatment Clinical Trials Demonstration was conducted from 1996 through March 2008 to improve access to promising new cancer therapies, assist in meeting the clinical trial goals of the National Cancer Institute (NCI), and assist in the formulation of conclusions regarding the safety and efficacy of emerging therapies in the prevention and treatment of cancer. Effective April 1, 2008, participation in cancer clinical trials was adopted as a permanent TRICARE benefit.

Note: TRICARE beneficiaries who began participation in the demonstration prior to its termination will continue to receive services as a demonstration participant until the beneficiary is discharged from the clinical trial.

There are 3 categories of NCI clinical trials:

- **Phase I trials:** TRICARE beneficiaries may be eligible to participate in Phase I trials if they meet certain requirements. Phase I trials are primarily concerned with assessing a drug's safety and tolerability.
- **Phase II trials:** TRICARE beneficiaries may participate in Phase II trials, which 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 trials:** TRICARE beneficiaries may also participate in Phase III trials, which compare promising new treatments against the standard approaches. These studies also focus on particular types of cancers.

## **Cost of Participation**

TRICARE will cost-share all medical care and testing required to determine eligibility for an NCI-sponsored trial. All medical care required as a result of participation in a trial will be processed under normal reimbursement rules (subject to the TRICARE maximum-allowable charge), provided each of the following conditions is met:

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

## **How to Participate**

Prior authorization is required to participate in an NCI clinical trial. Providers may use the *Cancer Clinical Trial (CCT) Patient Authorization* form to refer a TRICARE beneficiary into an NCI clinical trial. To download the form, visit [uhcmilitarywest.com](http://uhcmilitarywest.com) → Beneficiary → Find A Form → Clinical Programs.

Before beginning the evaluation or any treatment under the clinical trial, contact a UnitedHealthcare Cancer Clinical Trials Coordinator at (888) 899-4933 from 8 a.m.–5 p.m. MT.

Note: A beneficiary participating in an NCI clinical trial may still require a referral or authorization for non-NCI clinical trial services. Refer to the *Health Care Management and Administration* section of this Handbook for additional information.

The NCI website at cancer.gov lists some of the Phase I, Phase II, and Phase III NCI-sponsored clinical trials, but not all of them. To determine if there are clinical trials available, contact a Clinical Trials Coordinator at (888) 899-4933.

## **TRICARE Extended Care Health Option (ECHO)**

ECHO provides services to ADFMs who qualify based on specific mental or physical disabilities and offers beneficiaries an integrated set of services and supplies beyond those offered by the basic TRICARE health benefit programs (e.g., TRICARE Prime, TPRADFM, TRICARE Standard and TRICARE Extra).

Each beneficiary obtaining ECHO and associated program benefits is assigned to a case manager who will coordinate care with the PCM.

Potential ECHO beneficiaries must be ADFMs, have qualifying conditions, and be registered in the Exceptional Family Member Program (EFMP). Each service branch has its own EFMP and enrollment process. Under certain circumstances, this requirement may be waived. To learn more, contact the service branch's EFMP representative or visit [www.tricare.mil](http://www.tricare.mil). A record of ECHO registration is stored with a beneficiary's DEERS information.

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

- Moderate or severe mental retardation
- A serious physical disability
- An extraordinary physical or psychological condition of such complexity that the beneficiary is homebound
- A diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler (under age 3) that is expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability
- Multiple disabilities, which may qualify if there are 2 or more disabilities affecting separate body systems

TRICARE providers, especially PCMs, are responsible for managing care for TRICARE beneficiaries. Any TRICARE provider (PCM or specialist) may inform the patient's sponsor about the ECHO benefit. Beneficiaries should be referred to UnitedHealthcare for assistance with eligibility determination and ECHO registration. This assists the beneficiary and provider to gain more understanding of the benefit and have taken the necessary steps for efficient claims processing.

Active duty sponsors with family members seeking ECHO registration must enroll in their service's EFMP as required by their service branch. Retroactive registration into the ECHO program is not allowed.

### **ECHO Provider Responsibilities**

ECHO providers have certain responsibilities:

- Prior authorization must be obtained from UnitedHealthcare for all care provided under the ECHO program or providers run the risk of having ECHO claims denied.
- Providers may be requested to provide medical records or assist beneficiaries with completing EFMP documents.
- Network and participating providers must submit ECHO claims to PGBA.
- A provider rendering applied behavior analysis (ABA) must be a TRICARE-certified provider that meets one of the following criteria:
  - › Has a current state license to provide ABA services, or
  - › Is certified by the Behavior Analyst Certification Board™ as either a Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA), (Non-certified

paraprofessional providers may render certain educational intervention services and ABA under close supervision. For more information, see “DoD Enhanced Access to Autism Services Demonstration” later in this section.)

## **ECHO Benefits**

ECHO provides coverage for the following products and services:

- ABA (which includes the DoD Enhanced Access to Autism Services Demonstration, discussed later in this section) and other services that are not available through schools or other local community resources. ABA under the ECHO program is currently only offered under the Autism Services Demonstration as ABA is a basic TRICARE benefit
- Assistive services (e.g., those from a qualified interpreter or translator)
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)
- Rehabilitative services
- Respite care (during any month when at least 1 other ECHO benefit is received and limited to the United States, Guam, Puerto Rico, and the U.S. Virgin Islands)
  - › ECHO respite care: up to 16 hours of care
  - › EHHC respite care: up to 8 hours per day, 5 days per week
- Training to use special-education and assistive-technology devices
- Institutional care when a residential environment is required
- Transportation under certain limited circumstances (i.e., to and from institutions or facilities to receive otherwise-allowable ECHO benefits)

TRICARE may pay for “hands-on” ABA services provided by TRICARE-authorized providers. However, TRICARE does not pay for services provided by family members, trainers, or other individuals who are not TRICARE-authorized.

## **ECHO Home Health Care Benefit (EHHC)**

The EHHC benefit covers:

- Expanded respite care and in-home medically necessary skilled services through TRICARE EHHC
- EHHC respite care: up to 8 hours per day, 5 days per week to provide relief for the primary caregivers\*
- EHHC provides homebound beneficiaries requiring skilled, extended in-home health care services that are:
  - › Not limited to part-time or intermittent
  - › Capped by cost, not by hours (using the skilled nursing facility reimbursement rate)

For more information regarding the EHHC, refer to the *TRICARE Policy Manual*, Chapter 9, Section 15.1 at <http://manuals.tricare.osd.mil>.

## **ECHO Costs**

All ECHO services (except EHHC) accrue to the government’s maximum FY cost-share of \$36,000. Maximum cost-share limits under ECHO are per beneficiary, regardless of the number of dependents with the same sponsor receiving ECHO benefits in that period.

\* ECHO respite care benefits can only be used in a month when another ECHO benefit is being received. Both respite benefits (ECHO respite and EHHC respite) cannot be used in the same calendar month. The respite benefits cannot be used for siblings, employment, deployment, or pursuing education, respite benefits are not accumulative (i.e., unused hours cannot be carried over into the next month).

Costs for EHHC services **do not** accrue to the government's maximum FY cost-share.

Cost-shares under ECHO are in addition to those incurred for services provided under the basic TRICARE benefit (e.g., *TRICARE Prime*, *TPRADFM*, *TRICARE Standard* and *TRICARE Extra*).

Note: ECHO cost-shares do not accrue toward the catastrophic cap.

### **Prior Authorizations**

Providers must request prior authorization for all ECHO services.

### **Claims**

See the *Claims Processing and Billing Information* section of this Handbook for details on filing ECHO claims.

### **For More Information**

For more information regarding ECHO, refer to the *TRICARE Policy Manual*, Chapter 9 at <http://manuals.tricare.osd.mil>. Refer to the following resources for additional information and assistance:

- ECHO Information and Referral Line: (866) 212-0442
- ECHO Nurses: Call the UnitedHealthcare Case Management Center at (855) 874-6800 and enter the extension for the beneficiary's ECHO nurse. Note: ECHO beneficiaries should call the ECHO Information and Referral line (866) 212-0442 if they have lost or forgotten contact information for their ECHO nurse.
- ECHO fax number: (866) 269-5758
- UnitedHealthcare provider website: [uhcmilitarywest.com](http://uhcmilitarywest.com)
- ECHO website: [tricare.mil/echo](http://tricare.mil/echo)
- EFMP information: [militaryhomefront.dod.mil/efm](http://militaryhomefront.dod.mil/efm)

### **DoD Enhanced Access to Autism Services Demonstration**

The DoD Enhanced Access to Autism Services Demonstration was established to test the feasibility and advisability of permitting TRICARE reimbursement for Educational Interventions for Autism Spectrum Disorders delivered by paraprofessional providers. This demonstration provides information that will enable DoD to determine the following:

- If there is increased access to these services
- If the services are reaching those most likely to benefit from them
- If the quality of those services is meeting an appropriate standard of care currently accepted by the professional community of providers, including the Behavior Analyst Certification Board
- That state licensure and certification requirements, where applicable, are being met

The DoD Enhanced Access to Autism Services Demonstration allows non-certified educational intervention service providers, or tutors, to provide autism services to military family members in the United States. TRICARE Management Activity has extended the Enhanced Access to Autism Services Demonstration (ASD) through March 2014. UnitedHealthcare will administer the Enhanced Access to Autism Services Demonstration in the TRICARE West Region.

Please note that as of January 1, 2013 ABA Therapy is covered under the TRICARE Basic Benefit. This change has the following impacts:

- It is available to not only ADFM's but all eligible beneficiaries with a diagnosis of one of the Autism Spectrum Disorders

- This service is no longer under the ECHO program and is therefore not subject to an annual limit tied to the ECHO benefit
- ABA Therapy must be provided by BCBA or other qualified licensed professional at the Master’s level or above with appropriate training and experience in Applied Behavioral Analysis (at least two years) and is included as a competency in their license
- ABA Therapy can no longer be provided by BCaBA prepared practitioners
- This service requires prior approval based on an Outpatient Treatment Request with a plan that is consistent with the assessment and diagnosis
- It is subject to the same co-pays and deductibles that are consistent with all mental health services based on their plan type

Non-certified tutors may continue to provide ABA services under supervision. Authorized supervisors will be required to direct and oversee the tutors who provide the “hands-on” services and verify that the tutors are trained and able to perform the services required to treat beneficiaries with autism.

Note: The allowed cost of services provided by the DoD Enhanced Access to Autism Services Demonstration accrue to the ECHO FY government maximum limit. ABA Therapy no longer accrues to the ECHO FY government maximum limit. See “TRICARE Extended Care Health Option” earlier in this section for details.

For more information about the DoD Enhanced Access to Autism Services Demonstration, refer to the *TRICARE Operations Manual*, Chapter 18, Section 8 at <http://manuals.tricare.osd.mil>.

## **Supplemental Health Care Program (SHCP)**

TRICARE is derived from the Civilian Health and Medical Program of the Uniformed Services, which technically does not cover ADSMs (or National Guard and Reserve members on active duty). However, similar to TRICARE, the SHCP provides coverage for ADSMs (except those enrolled in TPR) and non-active duty individuals under treatment for LOD conditions. The SHCP also covers health care services ordered by an MTF provider for a non-ADSM MTF patient for whom the MTF provider maintains responsibility. Although the SHCP is funded by the DoD, it is separate from TRICARE and follows different rules. Only the following individuals are eligible for the SHCP:

- ADSMs assigned to MTFs
- ADSMs on travel status (e.g., leave, temporary assignment to duty, or permanent change of station)
- Navy or Marine Corps service members enrolled to deployable units and referred by the unit PCM or other provider who is not an MTF PCM
- National Guard and Reserve members on active duty
- National Guard members (LOD care only, unless beneficiary is on active federal service)
- National Oceanic and Atmospheric Administration personnel, U.S. Public Health Service personnel, cadets or midshipmen, and eligible foreign military personnel
- Non-active duty beneficiaries when they are inpatients in an MTF and are referred to a civilian facility for a test or procedure unavailable in the MTF, provided the MTF maintains continuity of care over the inpatient and the beneficiary is not discharged from the MTF prior to receiving services
- Comprehensive Clinical Evaluation Program participants
- Beneficiaries on the Temporary Disability Retirement List are eligible to obtain required periodic physical examinations



- Medically retired former members of the armed services enrolled in the Federal Recovery Coordination Program

Note: SHCP beneficiaries are not responsible for cost-shares, copayments, or deductibles.

### **Civilian Care**

When SHCP individuals need services that are not available at the MTF, the MTF physician issues a referral to a civilian provider. Care referred or authorized by the MTF and/or the MMSO will be covered under the SHCP. SHCP individuals are not responsible for deductibles, cost-shares, or copayments.

### **Referrals and Authorizations**

The MTF (if one is available) or the MMSO will initiate referrals for ADSMs and other designated patients to civilian specialists and sub-specialists for services that are beyond the scope of primary care. If it is determined that services are unavailable at the MTF, a *Referral For Civilian Medical Care (DD Form 2161)* (this form may vary by MTF site) will be completed and sent to UnitedHealthcare prior to sending the patient for specialty care. UnitedHealthcare and the MTF, as appropriate, will agree on a civilian provider to administer the care and will notify the patient. For non-MTF referred care, the SPOC will determine if the ADSM will receive care from an MTF or civilian provider.

Civilian providers should accept the electronic signature on forms (form number may vary) as valid ordering-physician signatures. There are numerous security mechanisms to ensure HIPAA compliance and that the electronic signature is made by the ordering DoD provider.

Electronic signatures can only be made by physicians and physician extenders with prescriptive and referral authority.

### **Provider Responsibilities**

Network providers are required to adhere to all contract requirements when treating SHCP individuals, including office and appointment access standards. Refer to the *Important Provider Information* section of this Handbook for more information about provider responsibilities.

UnitedHealthcare requires that all civilian providers who see referred SHCP individuals provide the referring MTF physician with a report detailing the consultation and any diagnosis or treatment plans in a timely manner. This will help provide continuity of care. Providers should also assist SHCP ADSMs in maintaining their medical records by having them sign an annual medical release form. A complete copy of the medical records, including copies of specialty and ancillary care documentation, must be provided to the service member within 30 calendar days of receiving the request. Network providers should refer to their contract for information regarding medical records copying fees reimbursement. Non-network providers may receive reimbursement for medical records copying fees by sending the charges on a standard invoice or statement to:

TRICARE West Region Claims Department  
P.O. Box 7064  
Camden, SC 29020 -7064

See the *Claims Processing and Billing Information* section of this Handbook for SHCP claims submission information.

Contact the case management staff at (888) 571-5232 for assistance or any questions.

### **Other Health Insurance and Third-Party Liability**

UnitedHealthcare will not apply OHI or third-party liability processing procedures to SHCP claims for outpatient active duty and non-TRICARE-eligible beneficiaries.

See the *Claims Processing and Billing Information* section of this Handbook for claims-submission information. For more information regarding the SHCP, visit [uhcmilitarywest.com](http://uhcmilitarywest.com) or call (877)988-WEST/(877)988-9378.

## **Transitional Health Care Benefits**

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

### **Transitional Assistance Management Program (TAMP)**

TAMP offers qualifying armed services members and their family members transitional health care benefits when the sponsor separates from active duty service.

The beneficiary may be enrolled in TRICARE Prime or may be using TRICARE Standard and TRICARE Extra. All referral, authorization, and claims-filing processes continue to apply. TRICARE Prime rules and access standards are the same during TAMP coverage. These beneficiaries must have valid uniformed services ID cards or CACs. See the *TRICARE Eligibility* section of this Handbook for information about verifying eligibility.

Note: TAMP deductibles do not apply to National Guard and Reserve members during this period. Additionally, LOD care is not covered under TAMP. See “Line-of-Duty Care for National Guard and Reserve Members” earlier in this section.

For more information on TAMP, visit [www.tricare.mil/tamp](http://www.tricare.mil/tamp).

### **Transitional Care for Service-Related Conditions (TCSRC)**

The TCSRC program extends TRICARE coverage for qualified former ADSMs who are diagnosed with service-related conditions during their 180-day TAMP period.

To qualify for TCSRC, a TAMP-eligible member’s medical condition must be:

- Service-related
- Newly discovered or diagnosed during the 180-day TAMP period
- Validated by a DoD physician
- Able to be resolved within 180 days, as determined by a DoD physician, from the date the condition is validated

The TCSRC benefit covers care only for the specific service-related condition; preventive and health maintenance care is not covered. TCSRC beneficiaries may seek care at MTFs or from TRICARE-authorized civilian providers if MTF care is not available. There are no copayments or cost-shares under TCSRC, and providers must submit claims in the same manner as other West Region claims are submitted. The TCSRC benefit is available worldwide.

For more information on TCSRC, visit [www.tricare.mil/tcsrc](http://www.tricare.mil/tcsrc).

### **Continued Health Care Benefit Program (CHCBP)**

CHCBP provides transitional benefits for a specified period of time (18–36 months) to former service members and their families, some unremarried former spouses, and emancipated children (living on their own) who enroll and pay quarterly premiums.

DoD has contracted with Humana Military Healthcare Services, Inc. (Humana Military) to administer the CHCBP. Humana Military issues beneficiaries a CHCBP ID card (shown in Figure 4.7 below) after enrollment is completed.

This card is different from a uniformed services ID card or a CAC. All questions regarding CHCBP eligibility verification can be addressed through Humana Military’s website at Humana-Military.com or by calling (800) 444-5445.

Note: UnitedHealthcare is unable to provide assistance with CHCBP inquiries.

**Continued Health Care Benefit Program Coverage**

The benefits available under CHCBP are similar to TRICARE Standard and TRICARE Extra, and although it is not part of TRICARE Standard and TRICARE Extra, it operates under most of the same rules. When providing care, the main differences to remember are that, under CHCBP, providers are not required to use or coordinate with MTFs because CHCBP beneficiaries are not eligible to receive military care or use MTFs (except for emergency care).

**Referrals and Authorizations**

All CHCBP referrals and authorizations are coordinated through Humana Military. Providers must seek authorization for care that is deemed medically necessary. Medical necessity rules follow TRICARE Standard and TRICARE Extra guidelines. Use one of the following numbers to coordinate CHCBP referrals and/or authorizations:

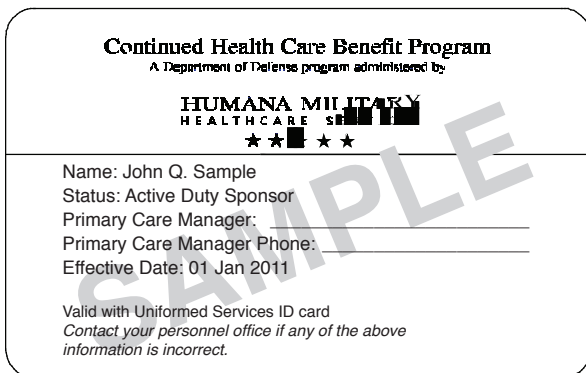
<b>Phone</b>	(800) 444-5445
<b>Fax</b>	(877) 270-9113

Note: Humana Military’s prior authorization requirements are not the same as those for UnitedHealthcare.

Humana Military has contracted with PGBA for CHCBP claims processing. See the [Claims Processing and Billing Information](#) section of this Handbook for more information about filing CHCBP claims.

**CHCBP ID Card**

**Figure 4.7**



**Medical Coverage**

TRICARE covers most inpatient and outpatient care that is medically necessary and considered proven. However, there are special rules or limits on certain types of care, while other types of care are not covered at all. Beneficiary liability for covered services is determined by the program option the beneficiary is using (e.g., TRICARE Prime, TRICARE Prime Remote [TPR], TRICARE Prime Remote for Active Duty Family Members [TPRADFM], TRICARE Standard and TRICARE Extra, TRICARE For Life [TFL], TRICARE Reserve Select [TRS], TRICARE Retired Reserve [TRR], TRICARE Young Adult). See the [TRICARE Program Options](#) section of this Handbook for specific beneficiary liability information.

This section provides information on covered services and specific details about some of the more complex benefits.

**This section is not all-inclusive.**

For additional information or answers to specific questions about TRICARE-covered services, visit [uhcmilitarywest.com](http://uhcmilitarywest.com), contact UnitedHealthcare at (877) 988-WEST/(877) 988-9378 , or review the *TRICARE Policy Manual*, *TRICARE Reimbursement Manual*, and *TRICARE Operations Manual* online at <http://manuals.tricare.osd.mil>. You may review the TRICARE Provider News publication for regular articles about benefits and program changes.

Some MTFs may offer services or procedures that are not covered by TRICARE. Beneficiaries should contact their local MTFs for more information about these services. Additionally, MMSO may authorize services for ADSMs that are not usually covered TRICARE benefits. As long as an authorization is in place, providers will be paid for providing non-covered services to beneficiaries according to TRICARE guidelines.

## **Covered Services**

Subject to applicable coverage rules and limits, TRICARE covers outpatient services such as:

- Routine office visits
- Outpatient office-based medical and ambulatory (same-day) surgical care
- Consultation, diagnosis, and treatment by a specialist
- Allergy tests and treatment
- Rehabilitation services (e.g., physical therapy, speech-language pathology, occupational therapy)
- Medical supplies used within the office, including casts, dressings, and splints
- Certain diagnostic radiology and ultrasound, diagnostic nuclear medicine, pathology and laboratory services, and cardiovascular studies

Subject to applicable coverage rules and limits, TRICARE covers medically necessary inpatient services, such as:

- Hospitalization in a semiprivate room (or in special care units when medically necessary) with general nursing, hospital service, and inpatient physician and surgical services
- Meals, including special diets
- Drugs and medications during an inpatient stay
- Operating and recovery room
- Anesthesia
- Laboratory tests
- X-rays and other radiology services
- Necessary medical supplies and appliances
- Blood and blood products

The services listed below will be discussed in more detail:

- Adjunctive dental care
- Ambulance services
- Clinical preventive services
- Durable medical equipment (DME)

- Emergency care
- Home health care
- Hospice care
- Injectable medications requiring prior authorization by UnitedHealthcare
- Maternity care
- Skilled nursing facility (SNF) care
- Urgent care
- Vision care

Refer to the Prior Authorization List at [uhcmilitarywest.com](http://uhcmilitarywest.com) for a list of the codes that require an authorization. Secure website users may also access the West Region Benefit Lookup tool to search additional information by Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code.

Inpatient and outpatient behavioral health care is also covered. See the [Behavioral Health Care Services](#) section of this Handbook for details about covered behavioral health care services.

### **Adjunctive Dental Care**

The TRICARE medical benefit covers adjunctive dental care. In most cases, adjunctive dental care is medically necessary in the treatment of an otherwise-covered medical (not dental) condition; is an integral part of the treatment of such medical condition; or is required in preparation for, or as the result of, dental trauma that may be or is caused by medically necessary treatment of an injury or disease.

These are some examples of adjunctive dental procedures that TRICARE may cover:

- Removal of teeth and tooth fragments to treat and repair facial trauma resulting from an accidental injury
- Total or complete ankyloglossia (tongue-tie) to alleviate difficulty swallowing or speaking (Partial ankyloglossia is not covered.)
- Dental or orthodontic care that is directly related to the medical and surgical correction of a severe congenital anomaly
- Dental care in preparation for, or as a result of, in-line radiation therapy for oral or facial cancer
- Treatment of acute (not chronic) myofascial pain/TMJ pain; care of these patients is subject to some additional restrictive guidelines:
  - › Treatment of this syndrome may be considered a medical problem only when it involves immediate relief of pain.
  - › Emergency treatment may include initial radiographs, up to 4 office visits, and the construction of an occlusal splint, if necessary to relieve pain and discomfort.
  - › Treatment beyond 4 visits, or any repeat episodes of care within a period of 6 months, must receive individual consideration and be documented by the provider of services.
  - › Occlusal equilibration and restorative occlusal rehabilitation are specifically excluded for myofascial pain dysfunction syndrome.

The TRICARE health care benefit does **not** cover non-adjunctive dental care, which refers to any routine, preventive, restorative, prosthodontic, periodontic, or emergency dental care that is not related to a medical condition. TRICARE may, however, cover medically necessary institutional and general anesthesia services in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental, or physical disabilities, or for pediatric patients age 5 or younger. TRICARE beneficiaries may receive non-



adjunctive dental services through military dental treatment facilities (DTFs) and through 1 of 3 TRICARE dental programs—ADDP, TDP, or TRDP—if enrolled. Refer to the *TRICARE Program Options* section of this Handbook for TRICARE dental options.

The following are examples of dental care that the TRICARE medical benefit does not cover when the care is not related to, or caused by, an underlying medical condition or congenital abnormality:

- Treatment of dental caries and periodontal disease
- Emergency room visits for dental conditions (i.e., dental pain)
- Extraction of teeth, including impacted wisdom teeth
- Provision of implants, crowns, dentures, and bridges

Care for accidental injury to the teeth alone is not considered adjunctive dental care and is not covered by the TRICARE medical benefit, whereas care for injury to the teeth resulting from the treatment of a medical condition, such as removing teeth fragments in order to treat facial trauma, is covered.

In some instances, hospital services and supplies may be covered for a patient who requires a hospital setting for non-covered, non-adjunctive dental care. For instance, a child with congenital heart disease and extensive dental disease who needs anesthesia during care may require care in a hospital to ensure hemodynamic stability during the treatment.

There are several important considerations concerning this benefit. First, medical documentation that establishes the severity of the patient's underlying medical condition must be submitted. (A primary care manager [PCM] or specialty care provider may need to submit this information.) Secondly, acute anxiety, behavioral issues, need for extensive treatment, or need for sedation/anesthesia do not, by themselves, qualify the patient for this coverage. The patient must still have a serious underlying medical condition unless he or she is age 5 or younger, or has developmental, mental, or physical disabilities. Finally, when coverage is authorized, it is only for facility fees, medical-supply coverage, anesthesiology services, and professional medical services related to the medical condition. General anesthesia cannot be provided by the attending dentist; it must be administered by a separate anesthesiology provider, regardless of the setting in which the general anesthesia is provided. The professional dentist's fees for the non-adjunctive dental care are not covered.

All adjunctive dental care requires prior authorization. The prior authorization process will determine if a beneficiary's condition requires adjunctive or non-adjunctive dental care. The prior authorization requirement is waived **only** when essential adjunctive dental care involves a medical emergency (e.g., facial injuries resulting from a car accident).

For a more detailed list of adjunctive dental procedures that TRICARE covers, refer to the *TRICARE Policy Manual*, Chapter 8, Section 13.1 at <http://manuals.tricare.osd.mil>.

### **Ambulance Services**

TRICARE covers ambulance services in the following circumstances:

- Emergency transport to a hospital
- Transfer from one hospital to another hospital more capable of providing the required care as ordered by a physician
- Transfers between a hospital or SNF and another facility for outpatient therapy or diagnostic services ordered by a physician
- Transfers to and from a SNF when medically indicated

Note: Payment of ambulance transfers to and from a SNF may be included in the SNF prospective payment system.

Air or boat ambulance is only covered when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities, and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated.

TRICARE does not cover ambulance services for these conditions:

- Non-emergency ambulance services used instead of a taxi service or other normal transportation means when the patient's condition would permit use of regular transportation (Ambulance transportation is covered under the TRICARE ECHO benefit when the beneficiary is being transported to and from institutions or facilities when the beneficiary is receiving institutional care.)
- Transport or transfer of a patient primarily for the purpose of having the patient closer to home, family, friends, or a physician
- Any type of medicabs or ambicabs that function as public passenger services transporting patients to and from medical appointments

For more information about ambulance services, refer to the *TRICARE Policy Manual*, Chapter 8, Section 1.1. For more information about patient transport services, refer to the *TRICARE Policy Manual*, Chapter 2, Section 6.1 at <http://manuals.tricare.osd.mil>.

## **Bariatric Surgery**

Bariatric surgery for morbid obesity is covered for TRICARE beneficiaries who meet all of the following 3 conditions:

1. The patient has either:
  - › A body-mass index (BMI) greater than or equal to 40 kg/m<sup>2</sup>.
  - › A BMI of 35-39.9 kg/m<sup>2</sup> with one clinically significant comorbidity including, but not limited to, cardiovascular disease, type 2 diabetes mellitus, obstructive sleep apnea, Pickwickian syndrome, hypertension, coronary artery disease, obesity-related cardiomyopathy, or pulmonary hypertension.
2. The patient has completed growth (age 18 or documentation of completion of bone growth).
3. The patient has been previously unsuccessful with medical treatment for obesity. Failed attempts must be documented in the patient's medical record.
  - › Commercially available diet programs or plans, such as Weight Watchers®, Jenny Craig, or similar plans, are acceptable methods of dietary management if there is concurrent documentation of at least monthly clinical encounters with a physician. However, these diet programs are not covered by TRICARE.
  - › Physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

When all of these conditions are met, TRICARE covers any of the following open or laparoscopic surgical procedures:

- Roux-en-Y gastric bypass
- Vertical banded gastroplasty
- Gastroplasty (stomach stapling)
- Adjustable gastric banding (i.e., adjustable LAP-BAND®)

TRICARE does **not** cover:

- Nonsurgical treatment of obesity or morbid obesity (commercial diet programs, weight-loss supplements)
- Redundant skin surgery when performed solely for the purpose of improving appearance
- Biliopancreatic bypass, gastric bubble or balloon, gastric wrapping/open banding, or sleeve gastrectomy for the treatment of morbid obesity
- Devices used for bariatric surgery not approved by the U.S. Food and Drug Administration (FDA)

Note: TRICARE only covers 1 bariatric surgery per lifetime. In certain medically necessary circumstances, TRICARE will also cover bariatric-revision surgery.

For more information on surgery for morbid obesity, refer to the *TRICARE Policy Manual*, Chapter 4, Section 13.2 at <http://manuals.tricare.osd.mil>.

### **Clinical Preventive Services**

Preventive care is not diagnostic and includes medical procedures not related directly to a specific illness, injury, or definitive set of symptoms or obstetrical care, but rather medical procedures performed as periodic health screening, health assessment, or health maintenance visits. Certain services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health.

### **Cancer Screenings**

#### • **Breast Cancer Screening:**

- › Clinical Breast Examination: For women under age 40, a clinical breast examination may be performed during a preventive health visit. For women age 40 and older, a clinical breast examination should be performed annually.
- › Mammograms: Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:
  - History of breast cancer, Ductal Carcinoma In Situ, Lobular Carcinoma In Situ, Atypical Ductal Hyperplasia, or Atypical Lobular Hyperplasia
  - Extremely dense breasts when viewed by mammogram
  - Known BRCA1 or BRCA2 gene mutation\*
  - First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves\*
  - Radiation therapy to the chest between ages 10 and 30
  - History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of 1 of these syndromes\*
- **Breast Screening Magnetic Resonance Imaging (MRI):** Covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20% or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:
  - › Known BRCA1 or BRCA2 gene mutation\*

\* Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service

- › First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves\*
  - › Radiation to the chest between ages 10 and 30
  - › History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of 1 of these syndromes\*
- **Colonoscopy:** Individuals at average risk for colon cancer are covered once every 10 years beginning at age 50. Individuals at increased and high risk for colon cancer are covered as follows:
    - › **Increased risk:** Once every 5 years for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp before age 60, or in 2 or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. Once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in 2 second-degree relatives.
    - › **High risk:** Once every 1 to 2 years for individuals with genetic or clinical diagnoses of hereditary non-polyposis colorectal cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20 to 25 or 10 years younger than the earliest age of diagnosis, whichever is earlier.

For individuals diagnosed with inflammatory bowel disease, chronic ulcerative colitis, or Crohn's disease, cancer risk begins to be significant 8 years after the onset of pancolitis or 10–12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every 1 to 2 years with biopsies for dysplasia.

Note: Computed tomographic colonography (CTC) is covered as a colorectal cancer screening only when an optical colonoscopy is medically contraindicated or cannot be completed due to a known colonic lesion or structural abnormality, or when other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is not covered as a colorectal cancer screening for any other indication or reason.
  - **Fecal occult blood testing:** Perform either guaiac-based or immunochemical-based testing of 3 consecutive stool samples annually starting at age 50.
  - **Human papillomavirus (HPV) deoxyribonucleic acid (DNA) testing:** HPV DNA testing is covered as a cervical cancer screening only when performed and billed in conjunction with a Pap smear, and only for women age 30 and older. The effective date for coverage of HPV DNA testing as a cervical cancer screening was September 7, 2010.
  - **Oral cavity and pharyngeal cancer screening:** A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol.
  - **Proctosigmoidoscopy or sigmoidoscopy:** Individuals at average risk for colon cancer are covered once every 3 to 5 years beginning at age 50. Individuals at increased and high risk for colon cancer are covered as follows:
    - › **Increased risk:** Once every 5 years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or 2 second-degree relatives.

\* Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service

- › **High risk:** Annual flexible sigmoidoscopy, beginning at age 10–12, for individuals with known or suspected familial adenomatous polyposis.
- **Prostate cancer:** Digital rectal examination and prostate-specific antigen screening annually for all men in the following categories:
  - › Age 50 or older
  - › Age 45 or older with a family history of prostate cancer in at least 1 other family member
  - › All African-American men age 45 or older regardless of family history
  - › All men age 40 and older with a family history of prostate cancer in 2 or more family members
- **Routine Pap smears:** Conduct annually starting at age 18 (or younger if sexually active) until 3 consecutive satisfactory normal annual examinations. Frequency may be less often at your and the patient's discretion, but not less than every 3 years.
- **Skin cancer:** Skin examination should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.
- **Testicular cancer screening:** Perform a clinical testicular physical examination annually for males ages 13–39 with history of cryptorchidism, orchiopexy, or testicular atrophy.
- **Thyroid cancer screening:** Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.

### **Cardiovascular**

A cholesterol test (non-fasting) should occur once every 5 years beginning at age 18. Blood pressure should be tested annually for children ages 3–6 and a minimum of every 2 years after age 6 (children and adults).

### **Clinical Preventive Examinations**

- **TRICARE Standard and TRICARE Extra:** A comprehensive clinical preventive examination is covered if it includes or is rendered at the same time as a covered immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening. See the individual screening services for frequency of coverage. School enrollment physicals for children ages 5–11 are covered. Annual sports and/or camp physicals are excluded.
- **TRICARE Prime:** In addition to the above, TRICARE Prime beneficiaries in each of the following age groups may receive 1 comprehensive clinical preventive examination without an accompanying immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening (1 examination per age group): 2–4, 5–11, 12–17, 18–39, and 40–64 years. While often rendered by a PCM, clinical preventive examinations and accompanying immunization and screenings may be performed by any network provider without a referral. For screening Pap smears, mammograms, or colonoscopies, see the individual services for frequency of coverage.

### **Hearing**

Preventive hearing examinations are only allowed under the well-child care benefit. All neonates should undergo audiology screening before leaving the hospital. However, if not tested at birth, all infants should undergo audiology screening before 1 month of age. Those who do not pass the audiologic screening should be tested before 3 months of age using evoked otoacoustic emission and/or auditory brainstem response testing. Evaluative hearing tests may be performed at other ages during routine examinations.



### **Human Papillomavirus Vaccine**

TRICARE follows the Centers for Disease Control and Prevention (CDC) guidelines for administering the HPV vaccine. The CDC recommends the vaccine for all females ages 11–26 who have not completed the vaccine series, regardless of sexual activity or clinical evidence of previous HPV infection. Ideally, the vaccination should be given before potential exposure to HPV through sexual activity and may be given as early as age 9. After age 26, no efficacy has been established; therefore, it is not a covered benefit. HPV DNA testing is covered as a cervical cancer screening only when performed in conjunction with a Pap smear, and only for women age 30 and older.

### **Immunizations**

TRICARE coverage will be extended for the age-appropriate dose of vaccines when:

- The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) for use in the United States
- The ACIP-adopted recommendations have been accepted by the director of the CDC and the secretary of the U.S. Department of Health and Human Services and published in a CDC *Morbidity and Mortality Weekly Report* (MMWR)

TRICARE coverage is effective the date the recommendations are published in the MMWR. Refer to the CDC's website at [CDC.gov](http://CDC.gov) for a current schedule of recommended vaccines.

Note: Immunizations recommended specifically for travel outside the United States are not covered, except for immunizations required for ADFMs whose sponsors have permanent change-of-station orders to overseas locations. These immunizations are covered as outpatient office visits.

TRICARE covers age-appropriate doses of annual influenza vaccines based on the current influenza season CDC guidelines.

### **Infectious Disease Screening**

Covered screenings for infectious diseases include hepatitis B, rubella antibodies, and HIV, and screening and/or prophylaxis for tetanus, rabies, Rh immune globulin, hepatitis B, meningococcal meningitis, and tuberculosis.

### **Lead Exposure Testing**

A blood lead test during each well-child visit from ages 6 months–6 years is covered if the assessment of risk for lead exposure is positive based on a structured questionnaire developed for the CDC.

### **Patient/Parent Education**

These education or counseling services may be rendered as part of an office visit but are not reimbursed separately:

- Accident and injury prevention
- Bereavement
- Cancer surveillance
- Dental health promotion
- Dietary assessment and nutrition
- Physical activity and exercise
- Safe sexual practices
- Stress
- Suicide-risk assessment
- Tobacco, alcohol, and substance abuse

### **Shingles Vaccine**

Per CDC-recommended guidelines, TRICARE covers a single dose of the shingles vaccine Zostavax® for beneficiaries age 60 and older.

### **Well-Child Care**

Well-child care (birth to age 6) includes routine newborn care; comprehensive health promotion and disease prevention examinations; vision and hearing screenings; height, weight, and head circumference; routine immunizations; and developmental and behavioral appraisal in accordance with American Academy of Pediatrics® and CDC guidelines.

### **Differences in Coverage Based on Beneficiary Program Option**

Coverage for clinical preventive services varies depending on whether a beneficiary is using TRICARE Prime or TRICARE Standard and TRICARE Extra.

TRICARE Prime:

- Offers enhanced vision coverage (See *Vision Care* later in this section for more details.)
- Enrollees do not need referrals or prior authorizations for clinical preventive services when using network providers\*
- There is no copayment when care is received from a TRICARE network provider

TRICARE Standard and TRICARE Extra:

- Routine eye examinations only covered for ADFMs, infants, and children up to age 6 (See *Vision Care* later in this section for more details.)
- Beneficiaries may have clinical preventive services performed by TRICARE-authorized network or non-network providers
- Cost-shares and deductibles apply for some services

For more information about TRICARE-covered clinical preventive services, refer to the *TRICARE Policy Manual*, Chapter 7, Sections 2.1–2.2 at <http://manuals.tricare.osd.mil>.

### **Durable Medical Equipment (DME)**

DME refers to medical equipment or supplies that your patient will need to arrest or reduce functional loss. DME must be ordered by a physician.

Refer to the Prior Authorization List at [uhcmilitarywest.com](http://uhcmilitarywest.com) for DME codes that require prior authorization. UnitedHealthcare clinical staff makes determinations based on medical necessity and TRICARE guidelines. Providers are required to follow Medicare's guidelines for rental/purchase requirements and submit claims with appropriate modifiers. DME guidelines specify DME that is always rented, always purchased, and rent-to-purchase options.

For more information about DME, refer to the *TRICARE Policy Manual*, Chapter 8, Section 2.1 at <http://manuals.tricare.osd.mil>.

For reimbursement purposes, DME is now defined as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Refer to the *TRICARE Reimbursement Methodologies* section of this Handbook for more information about DMEPOS reimbursement guidelines.

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\* ADSMs must have referrals and prior authorizations before receiving clinical preventive services, except for those enrolled in TPR when care is rendered by their primary care providers.

## Emergency Care

An emergency is defined as a medical, maternity, or psychiatric condition that would lead a prudent layperson (someone with average knowledge of health and medicine) to believe that a serious medical condition exists or that the absence of immediate medical attention would result in a threat to life, limb, or sight; or when the person manifests painful symptoms requiring immediate palliative effort to relieve suffering. This includes situations where a beneficiary arrives at the emergency room with severe pain (except dental pain), or is at immediate risk of serious harm to self or others. In the case of pregnancy, the danger to the health of the woman or her unborn child must be considered. In the absence of other qualifying conditions, pain associated with pregnancy or incipient birth after the 34th week of gestation when associated with a pregnancy, are not emergency conditions for adjudication purposes.

In the event of a life-, limb-, or eyesight-threatening emergency, the beneficiary should go, or be taken, to the nearest appropriate medical facility for care.

Note: Most dental emergencies, such as going to the emergency room for a severe toothache, are not a covered medical benefit under TRICARE. ADSMs receive dental care from military DTFs and, if necessary, from civilian providers through the TRICARE ADDP. Dependents may be eligible to enroll in either the TDP or the TRDP, depending on their sponsor's status. For more information refer to "TRICARE Dental Options" in the *TRICARE Program Options* section of this Handbook.

### **Notify UnitedHealthcare in Case of Emergency Admissions**

Providers must notify UnitedHealthcare within 24 hours of an emergency admission. This also applies to weekend notifications. Medical/surgical and maternity admission notifications should be sent by fax. Providers may fax face sheets to (877) 578-2738. Notification of outpatient observation is not required.

### **Home Health Care**

TRICARE's home health care benefits are similar to those covered under Medicare. To qualify for TRICARE coverage of any home health care services, the patient must meet each of the following criteria:

- Patient is confined to the home
- Services are provided under a plan of care established and approved by a physician
- Patient is under the care of the physician who approved the plan of care
- Patient needs 1 of the following types of services:
  - › Skilled nursing care that is reasonable and necessary (as defined in the *TRICARE Reimbursement Manual*, Chapter 12, Section 2)
  - › Psychiatric evaluation, therapy, and teaching (covered as a skilled nursing service)
  - › Intermittent skilled nursing care\*
  - › Skilled therapy services (i.e., physical therapy, speech-language pathology, or occupational therapy)

If a patient qualifies for coverage of home health care services, TRICARE covers a limited number of hours per week of either part-time or intermittent services. All home health care must be provided by a participating home health care agency.

It is important to note that assistance with activities of daily living (e.g., washing laundry, cleaning dishes) is not part of the home health benefit. While the home health care professional may provide some assistance with basic daily living care, these tasks are not separately reimbursable and are not the primary duties while in the patient's home.

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\* To meet the criteria for "intermittent" skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.

For more information about home health care, refer to the *TRICARE Reimbursement Manual*, Chapter 12 at <http://manuals.tricare.osd.mil>. For home health care benefits related to the TRICARE ECHO program, refer to the *TRICARE Policy Manual*, Chapter 9, Section 15.1 <http://manuals.tricare.osd.mil>.

### **Respite Care for Active Duty Service Members (ADSMs)**

TRICARE covers respite care for ADSMs who are homebound as a result of a serious injury or illness incurred while serving on active duty. The benefit provides rest for the primary caregiver caring for an injured or ill ADSM at home.

Respite care is available if the ADSM's plan of care includes frequent interventions by the primary caregiver. "Frequent" means that more than 2 interventions are required during the 8-hour period per day that the primary caregiver would normally be sleeping.

Respite benefits are limited to:

- A maximum of 40 respite hours in a calendar week
- No more than 5 days per calendar week
- No more than 8 hours per calendar day

There are no copayments, cost-shares, or dollar maximums.

The respite care must be provided by a TRICARE-authorized home health agency. When UnitedHealthcare receives a request from the military services for respite care, the following occurs:

- An authorization will be entered into UnitedHealthcare's medical management system.
- Services are authorized in 90-day increments.
- An authorization will be approved and a letter will be sent to the provider by fax or email. The beneficiary will receive a copy of the authorization letter. Both the beneficiary and the provider, when registered, may obtain immediate status of the authorization on the secure website at [uhcmilitarywest.com](http://uhcmilitarywest.com).

The ADSM is not required to be enrolled in the TRICARE ECHO program to receive this respite benefit.

Claims are submitted to PGBA in the same manner as other West Region claims.

For additional details on the respite care benefit for ADSMs, refer to the *TRICARE Operations Manual*, Chapter 7, Section 3 and Chapter 18, Addendum B at <http://manuals.tricare.osd.mil>.

### **Hospice Care**

TRICARE has adopted most of the provisions currently set out in Medicare's hospice coverage benefit guidelines, reimbursement methodologies, and certification criteria for participation in the hospice program. The hospice benefit is designed to provide palliative care to individuals with prognoses of less than 6 months to live if the terminal illness runs its normal course. This type of care emphasizes supportive services, such as pain control and home care, rather than cure-oriented treatment.

All TRICARE beneficiaries are eligible for the hospice benefit.

TFL beneficiaries do not need hospice authorizations from UnitedHealthcare. For additional information about TFL, please visit [tricare4u.com](http://tricare4u.com) or contact Wisconsin Physicians Service (WPS), (866) 773-0404.

Refer to the [Claims Processing and Billing Information](#) section of this Handbook and [uhcmilitarywest.com](http://uhcmilitarywest.com) for other health insurance requirements.

Hospice care must be provided by a Medicare-certified hospice agency. If the hospice provider is not currently TRICARE-certified, it may download the *Institutional Provider File Application* form by visiting [uhcmilitarywest.com](http://uhcmilitarywest.com) → Beneficiary → Find A Form → Certification.

**Exclusions**

There is no reimbursement for room-and-board charges for a patient who is receiving hospice services in the home. Room and board is not a covered hospice benefit when a patient is placed in a facility, such as a rest home, and the care is custodial. Patients also cannot receive other TRICARE services/benefits related to the treatment of the terminal illness for which hospice care is elected unless the hospice care is formally revoked. If not revoked, no treatment for the terminal illness is covered by TRICARE unless the hospice provides the treatment or arranges for it.

**Benefit Periods**

Hospice care is provided in 3 benefit periods, each of which requires a separate authorization:

- First 90-day period
- Second 90-day period
- Unlimited number of 60-day periods

**Levels of Hospice Care**

There are 4 levels of hospice care. All 4 levels are approved at the time of authorization of services. The hospice provider determines which level of care is appropriate for the patient. UnitedHealthcare does not require notification when the patient moves to a different level of hospice care:

- Routine home care
- Continuous home care
- Inpatient respite care (up to 5 days per month)
- General hospice inpatient care

**Revocation/Transfer to Another Hospice**

The beneficiary may choose to revoke or end hospice services at any time. The beneficiary also may decide to re-elect hospice at any time, but will forfeit the remaining days for the benefit period the beneficiary is in at the time the beneficiary revokes. Basic TRICARE coverage will be in effect following the revocation. The hospice must submit the patient's signed and dated revocation form to UnitedHealthcare by fax at (877) 890-8203. The beneficiary may choose to transfer to another hospice, up to 1 transfer during each election period. The beneficiary will stay in the current benefit period following the transfer. The hospice must submit the signed and dated transfer form, as well as the name of the hospice to which the care is transferred, to UnitedHealthcare by fax at (877) 890-8203.

**Hospice Referrals**

To initiate a hospice referral, a provider should select a TRICARE network hospice provider (when a network provider is available) and refer the patient to the hospice provider. Once the hospice receives the referral, it will contact the beneficiary for an evaluation. TRICARE does not require an authorization for the initial hospice evaluation. However, an authorization is required to receive hospice services. Once the patient elects hospice care, the hospice will submit an authorization request to UnitedHealthcare.

**Hospice Authorizations**

UnitedHealthcare requires the following items to be submitted at the time of initial authorization or recertification. It is the hospice provider's responsibility to provide the documentation to UnitedHealthcare.

For initial hospice authorization:

- Hospice providers must register for the secure provider website at [uhcmilitarywest.com](http://uhcmilitarywest.com). The initial hospice authorization should be submitted by fax.



- The patient hospice election form (also called hospice consent), signed and dated by the beneficiary, must be attached to the faxed request. UnitedHealthcare does not supply this form; each hospice has its own.

To download the *Hospice Authorization Form*, visit [uhcmilitarywest.com](http://uhcmilitarywest.com) → Beneficiary → Find A Form → Clinical Programs. After printing and completing the form, providers should fax it to UnitedHealthcare at (877) 890-9309. The patient hospice election form (also called hospice consent), signed and dated by the beneficiary, must be faxed with the authorization request.

For recertification, **each benefit period requires a separate authorization.** To request continuation of hospice services, only the hospice authorization needs to be submitted.

### **Hospice Claims and Reimbursement**

Hospice providers should submit claims electronically when possible. For more information about claims submission, refer to the *Claims Processing and Billing Information* section of this Handbook or visit [uhcmilitarywest.com](http://uhcmilitarywest.com).

Refer to the *TRICARE Reimbursement Methodologies* section of this Handbook for information on reimbursement for hospice services.

Note: There are no deductibles under the hospice benefit.

For more information about hospice care, refer to the *TRICARE Reimbursement Manual*, Chapter 11 at <http://manuals.tricare.osd.mil>.

### **Injectable Medications Requiring Prior Authorization by UnitedHealthcare**

Injectable medications that require physician or health care professional administration may require prior authorization by UnitedHealthcare. These medications may be dispensed in a provider's office or by a home health agency.

After becoming a registered user, providers may submit their authorization requests for injectable medications by fax. Go to [uhcmilitarywest.com](http://uhcmilitarywest.com) → Find a Form → Clinical Information → Injectable Medications, and download the *Clinical Information for Injectable Medications form*. Please fill out the form completely and legibly and fax it to UnitedHealthcare at the fax number listed on the form, along with any relevant clinical information. This form supplements, but does not replace, the *TRICARE Patient Referral/Authorization Form*.

After review and upon approval, the request is processed and the requesting provider will receive a copy of the form submitted to UnitedHealthcare. Allow 5 business days for UnitedHealthcare to process your request.

Note: Covered injectable medications and prior authorization requirements may vary between TRICARE retail network pharmacies and TRICARE Pharmacy Home Delivery. If UnitedHealthcare receives a request for a drug that should be obtained through a retail pharmacy or home delivery, the requesting provider will receive a letter from UnitedHealthcare with further guidance.

### **Maternity Care**

Maternity care involves the medical services related to prenatal care, labor and delivery, and postpartum care. Any woman eligible for TRICARE benefits can receive maternity care from the first obstetric visit through up to 6 weeks after the birth of the child. Women eligible for TRICARE benefits include ADSMs, spouses of ADSMs, certain eligible former spouses, retired service members, spouses of retired service members, and TRICARE-eligible unmarried children of active duty or retired service members.

Note: A newborn grandchild of an ADSM is not eligible for TRICARE unless the newborn is otherwise eligible as an adopted child or the child of another eligible sponsor.

### **Referrals and Authorizations**

If you are the PCM or primary care provider for a beneficiary who becomes pregnant, you will need to either refer her to an obstetrician or, if you are going to manage the pregnancy, handle the required prior authorizations throughout her pregnancy. Obstetric services require prior authorization from UnitedHealthcare for TRICARE Prime, TPR, and TPRADFM beneficiaries. The prior authorization should be obtained at the mother's first appointment with the PCM or primary care provider involving the pregnancy. The prior authorization will begin with the first prenatal visit and remain valid until 42 days after birth. Prior authorization must be obtained for both inpatient and outpatient services.

If your patient intends to deliver in a civilian (non-MTF) facility or birthing center, a separate prior authorization for the delivery portion of her maternity care must be obtained at the time of delivery. If the patient is a TRICARE Prime beneficiary, she must use a network facility for delivery.

Additional prior authorization is required for maternity inpatient stays (length of stay cannot be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section).

#### **Covered Services**

- Emergency cesarean section
- Epidural anesthesia for pain management during delivery
- Hospital-grade breast pumps for mothers of premature infants
- Medically necessary ultrasounds (e.g., to evaluate fetal well-being, growth, gestational age, or to evaluate or rule out complications); see additional information on ultrasounds later in this section
- Services and supplies associated with prenatal, childbirth, postpartum care, and complications
- TRICARE-authorized birthing centers

#### **Non-Covered Services**

- Home uterine activity monitoring (HUAM), telephonic transmission of HUAM data, or HUAM-related telephonic nurse or physician consultation
- Lymphocyte or paternal leukocyte immunotherapy for the treatment of recurrent spontaneous fetal loss
- Off-label use of FDA-approved drugs to manage uterine contractions
- Personal comfort items, such as private rooms and televisions after delivery
- Routine ultrasounds (e.g., to determine the sex of the fetus or for patients with low complication risks); see additional information on ultrasounds later in this section
- Salivary estriol test for preterm labor
- Services and supplies related to non-coital reproductive procedures (e.g., artificial insemination)

Note: A current list of non-covered services can be found on the No Government Pay Procedure Code List at [www.tricare.mil/nogovernmentpay](http://www.tricare.mil/nogovernmentpay).

### **TRICARE Maternity-Related Ultrasounds**

The professional and technical components of medically necessary fetal ultrasounds are covered in addition to the maternity global fee. The medically necessary indications include, but are not limited to, **clinical circumstances** that require obstetric ultrasounds to:

- Conduct a biophysical evaluation for fetal well-being
- Confirm cardiac activity

- Determine the cause of vaginal bleeding
- Diagnose or evaluate multiple gestations
- Estimate gestational age
- Evaluate a suspected ectopic pregnancy
- Evaluate fetal growth
- Evaluate maternal pelvic masses or uterine abnormalities
- Evaluate suspected hydatidiform mole
- Evaluate the fetus' condition in late registrants for prenatal care

Per American College of Obstetricians and Gynecologists guidelines, ultrasonography should be performed only when there is a valid medical indication. A physician is not obligated to perform ultrasonography for a patient who is at low risk and has no medical indications. Some providers offer all patients routine ultrasound screening as part of the scope of care after 16–20 weeks of gestation. **TRICARE does not cover routine ultrasound screening.** Only maternity ultrasound with a valid medical indication that constitutes medical necessity is covered by TRICARE.

Note: For rendering providers billing with a diagnosis of supervision of normal pregnancy, a **secondary diagnosis is required** to establish medical necessity of a diagnostic fetal ultrasound performed during a normal pregnancy. Otherwise, the claim will not be reimbursed. Primary prenatal care providers referring patients out to receive an ultrasound must provide the diagnosis (medical indications) to the rendering provider to justify medical necessity.

#### **Non-Medically Necessary Maternity Ultrasounds**

An ultrasound that does not have a valid medical indication (for example, an ultrasound to determine gender) is not covered by TRICARE, and payment may be the beneficiary's responsibility. If the beneficiary and the rendering ultrasound provider agree to perform an ultrasound that is not considered medically necessary, the ultrasound provider may only bill the beneficiary directly under certain conditions. For more information, see "Informing Beneficiaries about Non-Covered Services" under "Provider Responsibilities" in the *Important Provider Information* section of this Handbook.

For more information about maternity care, refer to the *TRICARE Policy Manual*, Chapter 4, Section 18.1 at <http://manuals.tricare.osd.mil>.

For updates on ultrasound coverage, refer to the UnitedHealthcare website at [uhcmilitarywest.com](http://uhcmilitarywest.com).

#### **Skilled Nursing Facility Care**

Skilled nursing care typically is not provided in a nursing home or a patient's home, but rather in a SNF. A SNF is required to be Medicare-certified and must enter into a participation agreement with TRICARE. Under the SNF benefit, TRICARE covers skilled nursing care and rehabilitative (physical, occupational, and speech) therapies, room and board, prescribed drugs, laboratory work, supplies, and medical equipment. TRICARE does not cover purely custodial care.

For TRICARE to cover a patient's admission to a SNF, the patient must have had a qualifying medical condition that was treated in a hospital for at least 3 consecutive days (not including day of discharge). Admission to the SNF may be covered as long as the patient is admitted within 30 days of his or her discharge from the hospital (with some exceptions for medical reasons). You will need to demonstrate the patient's need for skilled nursing services for TRICARE to pay for the SNF care.

For more information about SNF care, refer to the *TRICARE Policy Manual*, Chapter 2, Section 43.1 and the *TRICARE Reimbursement Manual*, Chapter 8 at <http://manuals.tricare.osd.mil>.

## Urgent Care

Urgent care services are medically necessary services that are required for illness or injury that would not result in further disability or death if not treated immediately. However, this type of illness/injury does require professional attention and has the potential to develop into such a threat if treatment is delayed longer than 24 hours.

An urgent care condition could be a sprain, sore throat, or rising temperature. Beneficiaries enrolled in TRICARE Prime, TPR, and TPRADFM should contact their PCMs/primary care providers or UnitedHealthcare before receiving urgent care. TRICARE Prime beneficiaries must receive referrals from their PCMs. If they do not receive a referrals, the claim may be paid under the point-of-service option.

## Vision Care

Routine and comprehensive eye examinations for evaluation of the eyes not related to another medical or surgical condition may be covered by TRICARE.

TRICARE's vision coverage varies based on beneficiary category and program option.

### **Active Duty Service Members (ADSMs)**

TRICARE Prime ADSMs must receive all vision care at MTFs unless specifically referred to network providers, or to non-network providers if network providers are not available. TPR ADSMs may obtain periodic eye examinations from network providers without authorization as needed to maintain fitness-for-duty status.

### **Active Duty Family Members (ADFMs)**

ADFMs are covered for 1 eye examination every 12 months, regardless of program option (e.g., TRICARE Prime, TRICARE Standard and TRICARE Extra). TRICARE Prime ADFMs must use a network optometrist or ophthalmologist, while TRICARE Standard and TRICARE Extra ADFMs may use any TRICARE-authorized optometrist or ophthalmologist.

### **Retired Service Members, Their Dependents, and Others**

Retired service members, their dependents, and others who are enrolled in TRICARE Prime are covered for eye examinations under TRICARE Prime's clinical preventive services benefit for 1 routine eye examination every 2 years by a network optometrist or ophthalmologist.

For retired service members, their dependents, and others using TRICARE Standard and TRICARE Extra, there is no vision coverage provided after age 6. Vision care for infants and children up to age 6 is covered under the well-child benefit.

### **TRICARE Well-Child Vision Benefit for Infants and Children up to Age 6**

Vision care coverage is provided under the TRICARE well-child benefit for all TRICARE-eligible infants and children up to age 6, regardless of program option. See Figure 5.1 for coverage details.

**TRICARE Well-Child Vision Care Coverage**

**Figure 5.1**

Beneficiary	Coverage	Provider
<b>Infants</b>	1 eye and vision screening at birth and 6 months	Primary care physician (e.g., pediatrician, family practitioner)
<b>ADFM Children (ages 3–6) TRICARE Prime</b>	1 routine eye examination every 12 months	Network optometrist or ophthalmologist
<b>ADFM Children (ages 3–6) TRICARE Standard</b>	1 routine eye examination every 12 months	Any TRICARE-authorized optometrist or ophthalmologist
<b>Non-ADFM Children (ages 3–6) TRICARE Prime</b>	1 routine eye examination every 2 years	Network optometrist or ophthalmologist
<b>Non-ADFM Children (ages 3–6) TRICARE Standard</b>	1 routine eye examination every 2 years	Any TRICARE-authorized optometrist or ophthalmologist

### **Eyeglasses, Contact Lenses, and Implantable Lenses**

ADSMs are covered for eyeglasses at MTFs at no cost. To obtain eyeglasses or contact lenses outside of the MTF, ADSMs should contact the Naval Ophthalmic Support and Training Activity via the website at [www.med.navy.mil/sites/nostra](http://www.med.navy.mil/sites/nostra) or by phone at (757) 887-7611.

For all other TRICARE beneficiaries, contact lenses or eyeglasses are only cost-shared with prior authorization for treatment of infantile glaucoma, keratoconus, dry eyes when normal tearing is inadequate or absent, corneal irregularities other than astigmatism, or loss of human lens function resulting from eye surgery or congenital absence.

Benefits are limited to only 1 set of implantable lenses required to restore vision. A set may include a combination of both implantable lenses and eyeglasses when the combination is necessary to restore vision. If there is a prescription change related to the qualifying eye condition, a new set may be cost-shared.

Replacement lenses for those that are lost, have deteriorated, or have become unusable due to physical growth are not covered. Adjustments, cleanings, and repairs of eyeglasses are not covered.

### **Other**

Medically necessary eye examinations are covered for all categories of TRICARE beneficiaries. TRICARE Prime beneficiaries need prior authorization for medically necessary visits if they are not performed at MTFs.

Diabetic beneficiaries enrolled in TRICARE Prime are covered for an eye examination each year, regardless of their sponsor's military status. There is no copayment for these examinations.

For more information about TRICARE's vision coverage, refer to the *TRICARE Policy Manual*, Chapter 7, Sections 2.1 and 2.2 at <http://manuals.tricare.osd.mil>. For more information on ophthalmological services related to a medical or surgical condition or to the medical or surgical treatment of a covered injury or illness, refer to the *TRICARE Policy Manual*, Chapter 7, Section 6.1 at <http://manuals.tricare.osd.mil>.

## **Limitations and Exclusions**

The following is a list of medical/surgical services generally not covered under TRICARE or covered with significant limitations. **This list is not all inclusive.** For more information, visit [uhcmilitarywest.com](http://uhcmilitarywest.com) or contact UnitedHealthcare at (877) 988-WEST/(877) 988-9378.

Secure website users of [uhcmilitarywest.com](http://uhcmilitarywest.com) may access the West Region Benefit Lookup Tool to query:

- Whether a service is a covered benefit
- Whether the service requires a referral or an authorization
- Whether the service needs medical review

### **Services or Procedures with Significant Limitations**

The following listed services are covered with significant limitations:

**Abortions:** Abortions are only covered when the life of the mother would be endangered if the fetus were carried to term. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided. MTFs may not be able to provide such services based upon limited capabilities (e.g., education, training, experience) of staff and facilities.

**Breast pumps:** Heavy-duty, hospital-grade electric breast pumps (including services and supplies related to the use of the pump) for mothers of premature infants are covered. An electric breast pump is covered while the premature infant remains hospitalized during the immediate postpartum period. Hospital-grade electric breast pumps may also be covered after the premature infant is discharged from the hospital with a physician-documented medical reason, such as the inability to breast feed. This documentation is also required for premature infants delivered in non-hospital settings. Breast pumps of any type, when used for reasons of personal convenience (e.g., to facilitate



a mother's return to work), are excluded even if prescribed by a physician. Manual breast pumps and basic (non-hospital grade) electric pumps are also excluded.

**Cardiac and pulmonary rehabilitation:** Both are covered only for certain indications. Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings is excluded.

**Chiropractic care:** Coverage is limited to ADSMs and is only available at specific MTFs under the Chiropractic Care Program. For more information, visit the TRICARE website at [www.tricare.mil/chiropractic](http://www.tricare.mil/chiropractic).

**Cosmetic, plastic, or reconstructive surgery:** Cosmetic, plastic, or reconstructive surgery is only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement after cancer surgery, or for breast reconstruction after cancer surgery.

**Cranial orthotic device or molding helmet:** Cranial orthotic devices are covered only for postoperative use for infants (3–18 months) who have undergone surgical correction of craniosynostosis and have moderate-to-severe residual cranial deformities. TRICARE does not cover devices and helmets for treatment of nonsynostotic positional plagiocephaly or for the treatment of craniosynostosis before surgery.

**Dental anesthesia and facility charges:** Medically necessary institutional and general anesthesia services may be covered to safeguard a patient's life or in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental, or physical disabilities or for pediatric patients age 5 or younger.

**Dental care and dental x-rays:** Both are covered only for adjunctive dental care.

**Diagnostic genetic testing:** Diagnostic genetic testing is covered only to confirm a clinical diagnosis that is already suspected based on a patient's symptoms. Services should be billed using the appropriate Evaluation and Management codes. Refer to the *TRICARE Policy Manual*, Chapter 6, Section 3.1. For antepartum services, refer to the *TRICARE Policy Manual*, Chapter 4, Section 18.2 at <http://manuals.tricare.osd.mil>.

**Education and training:** Education and training are only covered under the TRICARE ECHO program and diabetic outpatient self-management training services. Diabetic outpatient self-management training services must be performed by programs approved by the American Diabetes Association®, as evidenced by a Certificate of Recognition.

**Eyeglasses or contact lenses:** See *Vision Care* earlier in this section.

**Food, food substitutes and supplements, or other nutritional supplements:** Food and food substitutes are not covered. Nutritional therapy may be covered when medically justified as the primary source of nutrition (e.g., enteral or parenteral nutrition therapy).

**Hearing aids:** Hearing aids and certain repairs are covered only for ADFMs who meet specific hearing-loss requirements. Hearing aids are not covered for retired service members, their families, or others.

**Shoes, shoe inserts, shoe modifications, and arch supports:** Shoes and shoe inserts are covered only in very limited circumstances. Orthopedic shoes may be covered when they are a permanent part of a brace. For individuals with diabetes, extra-depth shoes with inserts or custom-molded shoes with inserts may be covered. For information on orthotics, refer to the *TRICARE Policy Manual*, Chapter 8, Section 3.1 at <http://manuals.tricare.osd.mil>.

**Vitamins:** Vitamins or minerals are not covered, unless used as a specific treatment of a medical condition.

## Exclusions

The following list of services are excluded under any circumstances. **This list is not all inclusive.** Visit [www.tricare.mil/nogovernmentpay](http://www.tricare.mil/nogovernmentpay) for more information.

- Acupuncture (may be offered at some MTFs and approved for certain ADSMs, but is not covered for care received by civilian providers)



- Alterations to living spaces
- Artificial insemination
- Autopsy services or postmortem examinations
- Birth control (nonprescription)
- Bone marrow transplants for treatment of ovarian cancer
- Camps or retreats (e.g., weight loss)
- Care or supplies furnished or prescribed by an immediate family member
- Diagnostic admission
- Experimental or unproven procedures
- Foot care (routine)
- Hair transplants
- Laser/LASIK/refractive corneal surgery
- Learning disability treatment or therapy
- Naturopaths
- Non-surgical treatment of obesity or morbid obesity

## Behavioral Health Care Services

This section will assist you with specific behavioral health care aspects of the TRICARE program. All of the behavioral health forms referred to in this section can be found on the UnitedHealthcare website at [uhcmilitarywest.com](http://uhcmilitarywest.com), under the “Find a Form” tab.

TRICARE covers services delivered by qualified, TRICARE-authorized behavioral health care providers practicing within the scope of their licenses, to diagnose and/or treat behavioral health components of an otherwise diagnosed medical or psychological condition.

The behavioral health care outpatient network consists of licensed outpatient providers, such as psychiatrists and other physicians, psychologists, social workers, marriage and family therapists, certified psychiatric nurse specialists, licensed or certified mental health counselors, and pastoral counselors. Services provided by a licensed or certified mental health counselor or pastoral counselor require physician referral and supervision. For more information, see *Visits to Licensed or Certified Mental Health or Pastoral Counselors* later in this section.

The TRICARE behavioral health inpatient network consists of hospitals, inpatient psychiatric units, Partial Hospitalization Programs (PHPs), Residential Treatment Centers (RTCs) and Substance Use Disorder Rehabilitation Facilities (SUDRFs).

### Determining Eligibility

Providers who are registered on the secure website can check eligibility at [uhcmilitarywest.com](http://uhcmilitarywest.com). For information on registering, see “UnitedHealthcare Web Site” in the *Welcome to TRICARE and the West Region* section of this Handbook.

### Behavioral Health Referral and Authorization Requirements

Providers should register on the secure website at [uhcmilitarywest.com](http://uhcmilitarywest.com) and submit prior authorization requests via fax for outpatient therapy. Select the appropriate profile in the “Request Type” drop-down menu. There

is a profile for “BH-Outpatient Therapy Individual-Family.” Please note that additional profiles are added periodically, and other profiles for behavioral health services may be added without notice. Providers should download the appropriate form at [uhcmilitarywest.com](http://uhcmilitarywest.com), under the “Find a Form” link, and fax the completed form to the appropriate number located at the bottom of the form (e.g., for outpatient therapy). Complete the *Preauthorization for Outpatient Treatment Request* form, and fax to (877) 581-1590.

Prior authorization requirements are listed below for each beneficiary category. In addition to these requirements, note that prior authorization is not required for emergency behavioral health inpatient admissions. Admissions resulting from a psychiatric emergency should be reported to UnitedHealthcare within 24 hours of the admission or the next business day after the admission, but must be reported within 72 hours of the admission. UnitedHealthcare will conduct a concurrent review for continuation of inpatient behavioral health services within 72 hours of emergency admissions and authorize additional days, based on medical necessity.

### **Active Duty Service Members**

ADSMs must have referrals and prior authorizations from their PCMs (or authorization from their service points of contact if enrolled in TPR), and authorization from UnitedHealthcare for any nonemergency behavioral health care services received from civilian network or non-network providers (except as provided under TPR regulations, if applicable). ADSMs are not eligible for the initial 8 self-referred visits, as described in the section below.

### **TRICARE Prime Remote and TRICARE Prime Remote for Active Duty Family Members**

Beneficiaries enrolled in TRICARE Prime (except ADSMs) and TPRADFM may see a network provider authorized under TRICARE regulations to see patients independently for the first 8 outpatient behavioral health care services per FY, (October 1– September 30) for a medically diagnosed and covered condition without a PCM referral or authorization from their regional contractor. Independent behavioral health providers generally include psychiatrists or other physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, and certified marriage and family therapists. Visits beyond the initial 8 self-referred visits require prior authorization from UnitedHealthcare.

Services provided by a licensed or certified mental health counselor or pastoral counselor require physician referral and supervision. For more information, see “Visits to Licensed or Certified Mental Health or Pastoral Counselors” later in this section.

Note: The first 8 self-referred visits only apply to an initial appointment and any follow-up visits that are related to a diagnosed medical or behavioral condition. Office visits for psychotropic pharmacologic management are routine medical services and do not count against the initial 8 visits for psychotherapy.

Upon the first visit, providers, if registered, may check eligibility at [uhcmilitarywest.com](http://uhcmilitarywest.com). It is important to note that the initial 8 visits per fiscal year are per beneficiary, not per provider. Ask the beneficiary if he or she has received previous behavioral health care. Providers do not need to “register” care or obtain referrals from UnitedHealthcare to document the initial 8 outpatient visits. Claims for these initial 8 visits will be processed without authorization. ADSMs may not self-refer for behavioral health care outside of the Military Treatment Facility (MTF).

Note: The initial 8 self-referred outpatient visits include initial evaluation, individual psychotherapy (typically 45–50 minutes per session), group psychotherapy, and family or conjoint psychotherapy when rendered in the diagnosis or treatment of a covered behavioral health disorder. Individual therapy exceeding 52 minutes is not routine and requires authorization.

After the first 8 self-referred outpatient visits, prior authorization is required. Servicing providers must submit authorization requests by fax, and must complete a *Preauthorization for Outpatient Treatment Request* form and fax it to (877) 581-1590. No additional sessions are authorized until the treatment request is reviewed.

Additionally, the following behavioral health care services require prior authorization for beneficiaries using TRICARE Prime and TPRADFM:

- Electroconvulsive therapy (ECT)
- ECHO
- Medication Management exceeding 2 visits a month
- Nonemergency inpatient admissions for substance use disorder or behavioral health care services
- Non-network provider services
- Partial hospitalization programs (PHPs)
- Psychoanalysis
- Psychological/neuropsychological testing
- Residential treatment center (RTC) programs

### **Beneficiaries Using TRICARE Standard and TRICARE Extra, TRICARE Reserve Select, TRICARE Retired Reserve, or TYA Standard**

Beneficiaries using TRICARE Standard and TRICARE Extra benefits, (including TRS, TRR, or TYA Standard), may see a provider authorized under TRICARE regulations to see patients independently for the first 8 outpatient behavioral health care services per FY for a medically diagnosed and covered condition without a referral or prior authorization from UnitedHealthcare. Independent behavioral health providers generally include psychiatrists or other physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, and certified marriage and family therapists. Visits beyond the initial 8 self-referred visits require prior authorization from UnitedHealthcare.

Services provided by a licensed or certified mental health counselor or pastoral counselor require physician referral and supervision. For more information, see *Visits to Licensed or Certified Mental Health or Pastoral Counselors* later in this section.

TRICARE Standard and TRICARE Extra, TRS, and TRR beneficiaries are encouraged to obtain care from TRICARE network providers, which reduces their out-of-pocket expenses.

Upon the first visit, providers, if registered, may check eligibility at [uhcmilitarywest.com](http://uhcmilitarywest.com) or call (877) 988-WEST/(877) 988-9378 for eligibility verification or other questions. It is important to note that the first 8 visits are per beneficiary, not per provider. Ask the beneficiary if he or she has received previous behavioral health care.

After the first 8 self-referred outpatient visits, prior authorization is required. Servicing providers must submit authorization requests by fax, and must complete and fax a *Preauthorization for Outpatient Treatment Request* form to (877) 581-1590. The request will be reviewed to determine whether continuing care meets InterQual criteria. No additional sessions are authorized until the treatment request is reviewed.

Note: The initial 8 self-referred outpatient visits include individual psychotherapy (typically 45-50 minutes per session), group psychotherapy, and family or conjoint psychotherapy when rendered for the diagnosis or treatment of a covered behavioral health disorder. Individual therapy exceeding 52 minutes is not routine and requires authorization.

Additionally, the following behavioral health care services require prior authorization:

- ECHO
- ECT
- Medication Management exceeding 2 visits per month

- Nonemergency inpatient admissions for substance use disorder or behavioral health care services
- PHPs
- Psychoanalysis
- Psychological/neuropsychological testing
- RTC programs

### **Beneficiaries Using Medicare and TRICARE**

Beneficiaries using Medicare as their primary payer are not required to obtain referrals or prior authorization from UnitedHealthcare for inpatient or outpatient behavioral health care services. These beneficiaries should follow Medicare rules for services requiring authorization. They may self-refer to any network or non-network provider who accepts Medicare. See the *How TRICARE For Life Works* section of this Handbook for more information about TRICARE and Medicare.

### **Visits to Licensed or Certified Mental Health or Pastoral Counselors**

Physician referrals and supervision are required for all visits to licensed or certified mental health or pastoral counselors, including the first 8 visits.

Physician supervision means the physician provides the overall medical management of the case. The referring physician does not have to be physically located on the premises of the provider to whom the referral is made. To assure appropriate case management, coordination must be made with the referring physician on an ongoing basis. Communication with the referring provider is an indication of medical management. This is a statutory and regulatory TRICARE program requirement that cannot be altered or waived.

The counselor must keep a copy of the referral in the patient's chart. When filing a claim, the counselor must indicate the referring physician's name in Box 17/17a/17b of the *CMS-1500* claim form to certify that he or she reported (or will report), in writing, treatment results to the referring physician, as requested.

Due to the similarity of the requirements for licensure, certification, experience, and education, pastoral counselors may elect to be authorized as either pastoral counselors or certified marriage and family therapists. Pastoral counselors who elect to be authorized as certified marriage and family therapists do not require physician referrals and supervision.

### **UnitedHealthcare Behavioral Health Portal**

The UnitedHealthcare Behavioral Health Portal provides self-service information and resources for all West Region TRICARE beneficiaries and providers. The Behavioral Health Portal is available 24 hours a day, 7 days a week at [uhcmilitarywest.com](http://uhcmilitarywest.com).

## **Outpatient Services**

### **Outpatient Psychotherapy**

Outpatient psychotherapy is a TRICARE-authorized benefit when it is determined to be medically or psychologically necessary for treatment of covered behavioral health components of an otherwise diagnosed medical or psychological condition. Benefits are payable for services when rendered in the diagnosis or treatment of a covered behavioral health disorder by an authorized, qualified behavioral health care provider practicing within the scope of his or her license. The following services are available for outpatient psychotherapy:

- Individual psychotherapy typically 45-50 minutes per session, up to 60 minutes when clinically indicated
- Family or conjoint psychotherapy (session not to exceed 90 minutes but may extend to 180 minutes for crisis intervention)

- Group psychotherapy (session not to exceed 90 minutes)
- Crisis intervention (individual psychotherapy session not to exceed 120 minutes; family or conjoint psychotherapy session not to exceed 180 minutes)
- Collateral visits
- Psychoanalysis\*

Outpatient psychotherapy is limited to a maximum of 2 psychotherapy sessions per week in any combination of individual, family, collateral, or group sessions. The following frequency limitations apply to outpatient psychotherapy:

- A provider will be allowed 1 psychiatric diagnostic interview examination per beneficiary, per year without authorization.
- If more than 1 diagnostic interview is needed within the same benefit period, prior authorization must be requested by fax using the *Preauthorization for Outpatient Treatment Request* form (benefit period is based on the FY October 1–September 30).
- A provider cannot bill for more than 2 sessions per calendar week (Sunday–Saturday) without prior authorization.
- 2 psychotherapy sessions may not be combined to circumvent the frequency limitation criteria (e.g., 30 minutes on 1 day may not be added to 20 minutes on another day and counted as 1 session).
- When multiple sessions of the same type are conducted on the same day (e.g., 2 individual sessions or 2 group sessions), only 1 session is reimbursed. Note: A collateral session may be conducted on the same day the beneficiary receives individual therapy.

### **Psychological and Neuropsychological Testing**

Psychological and neuropsychological testing requires prior authorization for outpatient settings. Prior authorizations are not required for inpatient settings as long as those services do not exceed the benefit limit of 6 hours for psych testing or 10 hours for neuropsych testing and are consistent with accepted application for evaluation.

Providers should submit their prior authorization requests by fax, using the *Preauthorization for Psychological/ Neuropsychological Testing* form. When completing the form, a provider may request an initial evaluation in conjunction with testing. The initial evaluation does not count toward the initial 8 self-referred outpatient visits.

Psychological testing must be medically necessary and performed in conjunction with otherwise-covered psychotherapy. Medical necessity must be established prior to the actual testing (i.e., there must be either a diagnosis or provisional diagnosis of a behavioral health disorder, and the testing must be appropriate for the diagnosis).

Psychological testing and assessment is limited to 6 hours per FY. However, additional hours may be approved on a case-by-case basis. Neuropsychological testing and assessment is limited to 10 hours per FY, based on industry standards and practice to avoid excessive reviews.

TRICARE does **not** cover the following psychological and neuropsychological testing:

- Psychological testing and assessment as part of an assessment for academic placement (including all psychological testing related to educational programs, issues, or deficiencies)
- Psychological testing for job placement
- Psychological testing for child-custody disputes

\* Psychoanalysis requires prior authorization from UnitedHealthcare.

- Psychological testing done for general screening (in the absence of specific symptoms of a covered mental disorder) to determine if individuals being tested are suffering from a behavioral health disorder
- Teacher and parental referrals for psychological testing
- For the Reitan-Indiana battery when administered to a patient under age 5 and for self-administered tests to a patient under age 13
- Testing to determine whether a beneficiary has a learning disability if the primary or sole basis for the testing is to assess for a learning disability
- Testing related to diagnosed specific learning disorders or learning disabilities (encompasses reading disorder [also called dyslexia], mathematics disorder, disorder of written expression, and learning disorder not otherwise specified)

Note: Testing for a patient in an RTC or PHP is included in the payment rate and cannot be separately reimbursed. Also, payment billed by an individual professional provider not employed by or under contract with the RTC or PHP is included in the payment rate.

### **Medication Management**

Medication management is covered when provided as an independent procedure and rendered by a TRICARE-certified provider practicing within the scope of his or her license. TRICARE pays for up to 2 medication management visits per month without prior authorization. Prior authorization is required for medication management sessions exceeding 2 visits per month.

When a provider is performing medication management along with therapy, prior authorization is required. The provider must submit an authorization request by fax and submit a *Preauthorization for Outpatient Treatment Request* form to UnitedHealthcare to obtain this prior authorization, unless the sessions fall within the initial 8 self-referred outpatient visits.

### **Electroconvulsive Therapy**

ECT is covered when determined to be medically necessary. Prior authorization is required. To be considered for payment, providers must request prior authorization for all ECT components (the facility, the psychiatrist, and the anesthesiologist). A *Preauthorization for Electroconvulsive Therapy (ECT)* form must be submitted to UnitedHealthcare for approval. At this time, an online profile for ECT is not available. Inpatient ECT is included in the hospital's inpatient payment.

## **Inpatient Services**

### **Inpatient Psychotherapy**

Inpatient psychotherapy is limited to 5 sessions of any kind of psychotherapy per calendar week (Sunday–Saturday), unless medical review of the overall treatment plan for medical necessity and appropriateness is conducted.

Note: Facilities with all-inclusive contracts that include psychotherapy will not receive separate payment for inpatient psychotherapy.

All facilities, whether hospital-based or freestanding, must adhere to the balance billing, release of medical records, and waiver of non-covered services provisions outlined in the *Important Provider Information* section of this Handbook.

### **Acute Inpatient Care**

The purpose of acute inpatient care is to stabilize a life-threatening or severely disabling behavioral health condition. TRICARE defines a psychiatric emergency admission as an admission when, based on a psychiatric



evaluation performed by a physician (or other qualified behavioral health care provider with hospital admission authority), the beneficiary is at immediate risk of serious harm to self or others as a result of a behavioral health disorder and requires immediate continuous skilled observation at the acute level of care. In a life-threatening situation, the provider should direct the beneficiary to the closest appropriate health care facility. If an MTF is geographically available, referral to the MTF emergency room is appropriate. The beneficiary's age at the time of admission determines the actual number of benefit days that can be authorized for acute inpatient care per FY. The limits are as follows:

- Up to 30 days for beneficiaries age 19 and older
- Up to 45 days for beneficiaries age 18 and younger

An inpatient admission for substance use detoxification and rehabilitation counts toward the 30-or 45-day limit per FY for inpatient behavioral health care services, regardless of whether the beneficiary is admitted to a general hospital or substance use disorder rehabilitation facility (SUDRF).

Prior authorization is required for all nonemergency admissions. Admissions resulting from a psychiatric emergency should be reported to UnitedHealthcare within 24 hours of the admission or the next business day after the admission, but must be reported within 72 hours of the admission. UnitedHealthcare will conduct a concurrent review for continuation of inpatient behavioral health care services and authorize additional days, as medically necessary. Admissions may be reported by faxing a completed *Inpatient Emergency Admission—Mental Health* form to UnitedHealthcare at (877) 581-1590.

Waivers to the maximum benefit day limitation may be granted if the continued care meets certain requirements. Waiver requests must be submitted before the benefit is exhausted and can be granted only by the UnitedHealthcare behavioral health medical director. This is true of both inpatient care and partial hospitalization.

### **Psychiatric Partial Hospitalization Programs (PHP)**

Partial hospitalization is treatment where the patient spends at least 3 hours a day, not to exceed 5 hours a day, 5 days a week at the facility (the treatment may also occur during weekends or evenings), but then goes home at night. A psychiatric PHP provides an appropriate setting for crisis stabilization or treatment of partially stabilized behavioral health disorders. It also serves as a transition from an inpatient program when medically necessary.

A TRICARE-authorized psychiatric PHP can be either a distinct part of an otherwise TRICARE-authorized institutional provider or a freestanding program:

- Hospital-based PHP: A hospital-based PHP is not required to have separate TRICARE certification from the TRICARE Quality Monitoring Contractor (TQMC), the Keystone Peer Review Organization (KePRO). A PHP that is part of a TRICARE-authorized hospital is also considered TRICARE-authorized.
- Freestanding PHP: A freestanding PHP must be TRICARE-certified by KePRO and must enter into a participation agreement with TRICARE. See the *Important Provider Information* section of this Handbook for more information regarding participation agreements. See the *TRICARE Quality Monitoring Contractor* section of this Handbook for more information on KePRO.

A psychiatric PHP facility must be capable of providing an interdisciplinary program of medically therapeutic services at least 3 hours per day, not to exceed 5 hours a day, up to 5 days per week. This can include day, evening, or weekend treatment.

Psychiatric PHP coverage details:

- Referrals and prior authorizations are required for all psychiatric PHP admissions. A *Preauthorization for Partial Hospitalization* form must be completed and faxed to (877) 581-1590. At this time, an online profile for PHP is not available.

- Psychiatric PHP care is limited to a maximum of 60 treatment days (whether a full-day or half-day program) per FY or for any single admission. The limit may be waived if the treatment is determined to be medically necessary.
- The 60 psychiatric PHP treatment days are not offset by, nor counted toward, the inpatient limit of 30 days for beneficiaries age 19 and older or 45 days for beneficiaries age 18 and younger.
- Concurrent medical necessity reviews are conducted during the course of the stay.
- Waivers to the maximum benefit day limitation may be granted if the continued care meets certain requirements. Waiver requests must be submitted before the benefit is exhausted and can be granted only by the UnitedHealthcare behavioral health medical director.

**Filing Claims for Facilities Subject to the Outpatient Prospective Payment System**

The TRICARE outpatient prospective payment system (OPPS) is used to pay claims filed for hospital outpatient services, including hospital-based PHPs subject to TRICARE’s prior authorization requirements. TRICARE OPPS is mandatory for both network and non-network providers.

TRICARE has adopted Medicare’s reimbursement methodology for hospital-based PHPs. There are 2 separate ambulatory payment classification (APC) payment rates under this reimbursement methodology:

- APC 0175: For days with 3 services
- APC 0176: For days with 4 or more services

TRICARE allows physicians, clinical psychologists, clinical nurse specialists, nurse practitioners, and physician assistants to bill separately for their professional services delivered in a PHP. The only professional services that are included in the PHP payment are those furnished by clinical social workers, occupational therapists, and alcohol and addiction counselors.

To bill for partial hospitalization services under the hospital-based OPPS, hospitals are to use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and revenue codes and report psychiatric partial hospitalization services under bill type 013X, along with condition code 41 on the *UB-04* claim form. The revenue code and HCPCS code must be billed separately for each date of service.

**Filing Claims for Facilities Not Subject to the Outpatient Prospective Payment System**

Facilities not subject to OPPS including children’s hospitals, VA and freestanding PHPs (psychiatric and SUDRFs) will continue to be reimbursed under the PHP payment subject to TRICARE’s prior authorization requirements.

**Residential Treatment Centers (RTCs)**

RTCs provide treatment for children and adolescents (some centers may provide treatment up to age 21) who require behavioral health care due to a serious behavioral health disorder. Children who only have disciplinary problems or primary substance use disorders do not qualify for treatment in an RTC setting.

All RTCs must be TRICARE-certified by the TQMC, KePRO, to provide residential treatment to TRICARE-eligible beneficiaries. Providers may contact KePRO by any of the following means:

<b>Mail</b>	KePRO ATTN: TRICARE Operations 777 East Park Drive Harrisburg, PA 17111
<b>Phone</b>	(877) 841-6413
<b>Email</b>	tricare@kepro.com

A psychiatrist or clinical psychologist must recommend the child be admitted to the RTC, and a psychiatrist or clinical psychologist must direct the development of a treatment plan. Documentation must be submitted to support each request, and the behavioral health disorder must meet clinical review criteria before admission can be authorized.

Additional RTC details:

- RTC care is covered to a maximum of 150 days per FY or for a single admission, when medically or psychologically necessary. These limits are subject to waiver in certain cases.
- Prior authorization is required. The *Residential Treatment Center (RTC) Application* must be completed and faxed to (877) 581-1590. At this time, an online profile for RTC care is not available. Facilities must be TRICARE authorized. Admission primarily for substance use rehabilitation is not authorized.
- Concurrent medical necessity reviews are conducted during the course of the RTC stay.

TRICARE reimbursement for RTC care is an all-inclusive rate. The only 3 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 the therapy is provided to 1 or both of the child's parents residing a minimum of 250 miles from the RTC. Prior authorization is required for all geographically distant family therapy.
- **RTC educational services:** Educational services will be covered only in cases when appropriate education is not available from or not payable by local, state, or federal governments. TRICARE is always the last payer. For network providers, this coverage limitation applies only if educational services are not part of the contracted rate.
- **Non-behavioral health care services:** Services provided to the beneficiary not related to behavioral health care, such as medical treatments for asthma or diabetes, may be reimbursed separately from the RTC.

## Alcoholism and Other Substance Use Disorders

Substance use disorder treatment is only covered when provided by a TRICARE-authorized hospital or an organized substance use disorder treatment program in a TRICARE-authorized freestanding or hospital-based SUDRF. Treatment may include outpatient and/or inpatient services.

### Outpatient Care for Alcoholism or Other Substance Use Disorders

TRICARE provides coverage for up to 60 facility-based outpatient therapy visits (individual or group) over the course of a benefit period, beginning the first day of the rehabilitation phase of treatment. Family therapy is covered for up to 15 visits per benefit period, beginning the first day of therapy.

Non-facility-based outpatient services are not a covered benefit for a beneficiary with a primary diagnosis of substance use disorder/dependence. All outpatient substance use disorder services must be provided in a TRICARE-authorized freestanding or hospital-based SUDRF. However, it may be covered if a co-occurring mental health condition is a part of the presenting problem and a focus of treatment.

Waivers to the maximum benefit day limitation may be granted if the continued care meets certain requirements. This also applies to both inpatient care and partial hospitalization. Exceptions will be considered based on medical necessity review, or by meeting the standards for waivers. For more information refer to the TRICARE Policy Manual, Chapter 7, Section 3.7.

### Inpatient Detoxification

Detoxification services are covered when medically necessary for the active medical treatment of the acute phases of substance use withdrawal (detoxification), for stabilization, and for the treatment of medical complications of

substance use disorders. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required.

The following details apply to detoxification:

- Covered for up to 7 days per episode in a TRICARE-authorized SUDRF, if medically necessary
- Counts toward the maximum of 30- or 45-days (depending on the patient's age) of inpatient behavioral health care allowed per FY
- Does not count toward the 21 days of rehabilitation addressed in the following section, *Substance Use Rehabilitation*

### **Substance Use Rehabilitation**

Rehabilitative care may occur in an inpatient or partial hospitalization setting. Care must be provided at TRICARE-authorized SUDRFs.

The following details apply to substance use rehabilitation:

- Prior authorization is required for rehabilitation stays. A *Preauthorization for Inpatient Substance Abuse Rehabilitation* form or *Preauthorization for Partial Hospitalization* form must be completed and faxed to (877) 581-1590. At this time, an online profile for substance use rehabilitation is not available.
- Care is covered for up to 21 days of rehabilitation per benefit period in a TRICARE-authorized SUDRF (includes inpatient and partial hospitalization days or a combination of both).
- Coverage is subject to the following limits:
  - › 1 treatment episode in a 1-year benefit period (begins with the first day of treatment and ends 365 days later)
  - › 3 treatment episodes during a person's lifetime
  - › Days for rehabilitation count toward the 30- or 45-day limit per FY (depending on the patient's age) for acute inpatient psychiatric care
- TRICARE shares the cost of SUDRF partial hospitalization rehabilitation treatment for up to 21 days at a predetermined, all-inclusive rate.
- PHP SUDRFs must submit charges for substance use disorder treatment on a *UB-04* form.

For information on PHP claims, see the *Claims Processing and Billing Information* section of this Handbook.

### **Court-Ordered Care**

Court-ordered care is defined by TRICARE as medical services, including inpatient admissions, which a party in a legal proceeding is ordered or directed to obtain by a court of law. The fact that behavioral health care services are ordered by a court for a TRICARE-eligible beneficiary does not determine the benefits available under TRICARE. TRICARE benefits are paid only if the services are medically or psychologically necessary to diagnose and/or treat a covered condition and are for covered TRICARE services provided by a TRICARE-authorized provider. 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.

### **Non-Covered Behavioral Health Care Services**

The following are examples of behavioral health care services not covered under TRICARE. **This list is not all-inclusive.**

- Aversion therapy (including electroshock and the use of chemicals for alcoholism, except for Antabuse® [disulfiram], which is covered for the treatment of alcoholism)

- Behavioral health care services and supplies related solely to obesity and/or weight reduction
- Biofeedback for psychosomatic conditions
- Counseling services that are not medically necessary in the treatment of a diagnosed medical condition (e.g., educational counseling, vocational counseling, nutritional counseling, stress management, marital therapy, lifestyle modifications)
- Custodial nursing care
- Diagnostic admissions
- Educational programs
- Experimental procedures
- Marathon therapy
- Medical hypnosis
- Megavitamin or orthomolecular therapy
- Psychosurgery (surgery for the relief of movement disorders, electroshock treatments, and surgery to interrupt the transmission of pain along sensory pathways are not considered psychosurgery)
- Services and supplies that are not medically or psychologically necessary for the diagnosis and treatment of a covered condition
- Services for V-code or Z-code diagnoses
- Sexual dysfunction therapy (see “Sexual Disorders” later in this section)
- Surgery performed primarily for psychological reasons (such as psychogenic)
- Therapy for developmental disorders such as dyslexia, developmental mathematics disorders, developmental language disorders, and developmental articulation disorders
- Unproven drugs, devices, and medical treatments or procedures

### **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:

- Gender identity disorders—characterized by strong and persistent cross-gender identification accompanied by persistent discomfort with one’s assigned gender
- Orgasmic disorders (e.g., female orgasmic disorder, male orgasmic disorder, premature ejaculation)
- Paraphilias (e.g., exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism, and paraphilia not otherwise specified)
- Sexual arousal disorders (e.g., female sexual arousal disorder, male erectile disorder)
- Sexual desire disorders (e.g., 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 (e.g., dyspareunia, vaginismus)
- Substance-induced sexual dysfunction

## **Behavioral Health Care Management**

For information about claims processing and billing, refer to the *Claims Processing and Billing Information* section of this Handbook.

For information about case management, refer to the *Health Care Management and Administration* section of this Handbook.

For information about provider credentialing and contracting, refer to the *Important Provider Information* section of this Handbook.

### **Discharge Planning**

Discharge planning is an important function that facilitates the transition of the beneficiary into a less restrictive level of care. Behavioral health care providers are expected to make discharge planning a routine part of treatment. As part of the concurrent review process, the UnitedHealthcare Utilization Management (UM) staff reviews the discharge plan with the provider and assists the provider in identifying available resources within the admitting facility, the community, and the network.

### **Aftercare Planning**

Aftercare planning is thorough and unique to each case. As part of the process, the UnitedHealthcare UM department reviews the treatment plan and aftercare planning with the treating clinician every few days. The provider updates the treatment plan as appropriate to maintain an accurate record of the beneficiary's progress through the continuum of care. As the time of discharge from the inpatient setting approaches, the aftercare plan becomes more concrete and the next level of care is identified (e.g., partial hospitalization, outpatient therapy). At this point, the specific provider of the next level of care is identified and the first appointment is scheduled.

During the concurrent review, the facility's utilization review clinician must notify the UnitedHealthcare clinician of the beneficiary's discharge date, discharge diagnosis, discharge medications, and aftercare plans, including the date of the first scheduled outpatient appointment.

## **Behavioral Health Care Medical Record Documentation**

The following information must be included in each beneficiary's record. The credentials or provider type for each provider represented in the record should appear at least once.

- Beneficiary identification (name and identification number) on each page
- Allergies
- Immunization status
- Date of visit
- Chief complaint/problem
- History of problem
- Physical assessment
- Diagnosis/impression
- Treatment plan goals
- Appropriate discharge planning
- Legible provider name(s)/signature(s)
- Consent to treatment forms
- Pertinent legal information



## Initial Evaluation

The medical record of the beneficiary's initial evaluation must contain a description and history of the presenting problem(s), including precipitating factors, as well as the items discussed below. A mental status examination is part of every treatment record and should include beneficiary information on the following:

- Orientation to person, place, time, and situation
- Affect and mood
- Speech and thought content
- Judgment, insight, and impulse control
- Attention, concentration, and memory
- A detailed medical and behavioral health history including:
  - › Previous practitioners and treatment dates
  - › Therapeutic interventions and responses
  - › Sources of clinical data
  - › Relevant family information
  - › Results of laboratory and psychological tests
  - › Consultation reports

An appropriately detailed psychosocial history includes items about family, education, occupation, relevant legal information, and relationship/social histories. For children and adolescents, the detailed psychosocial history must include:

- Prenatal and perinatal events
- A development history, including physical, psychological, social, intellectual, and academic spheres
- Information about the presence or absence of medication use and other substance use (If prescribed by the practitioner, notations must clearly indicate all dosages, dates of initial prescriptions, and refills.)
- A list of relevant medical conditions, prominently identified and revised
- List any known medications that the beneficiary is taking
- Information about the presence or absence of allergies and sensitivities to pharmaceuticals and other substances
- A completed substance use disorder evaluation for beneficiaries age 12 and older that includes past and present use of alcohol, tobacco products, caffeine, and prescribed and over-the-counter drugs
- A risk assessment and information about special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential (must include updated management plans)
- A five-axis *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR or its successor)* diagnosis consistent with the presenting problem(s), history, mental status examination, and other assessment data
- Documentation that a follow-up appointment has been scheduled

## Treatment Plan Documentation

The treatment plan documentation should make clear the relationship between the diagnosis/case formulation and the treatment plan. The treatment plan must include:

- Objective, measurable goals
- Estimated time frames for goal attainment or problem resolution
- Evidence of the beneficiary's understanding of the treatment plan
- Ongoing review of the beneficiary's progress and the effectiveness of the treatment plan

### **Progress Noted in Treatment Records**

Progress notes must describe the beneficiary's strengths and limitations in achieving treatment plan goals, including environmental factors that support change or may serve as obstacles to progress. These progress notes must include:

- Documentation that all concurrent, relevant caregivers (e.g., consultants, primary physicians, ancillary practitioners, health care institutions) are contacted or involved in treatment and show evidence of continuity and coordination of care. (Note: Also indicate if none of the above caregivers is involved.)
- Documentation that the beneficiary is referred for, and receiving medication evaluation for, psychotropic medication, if applicable
- Dates of subsequent appointments at each contact
- A discharge plan, when appropriate, that includes:
  - › Final five-axis DSM-IV-TR (or its successor) diagnosis
  - › Discharge summary
  - › Discharge instructions given to beneficiary or family
  - › Documentation of the beneficiary's achievement of goals or necessary referrals to assist in the final attainment of goals
  - › Documentation of the beneficiary's perception of goals being achieved/not achieved

### **Medication Management Records**

To adhere to TRICARE procedures and requirements, medication management records must include:

- A completed medication flow sheet or progress notes documenting current psychotropic medication(s), dosage(s), and date(s) of dosage changes
- Documentation of beneficiary education regarding possible medication side effects
- Documentation that the reason for medication was explained to the beneficiary
- Documentation of education for women of childbearing age to avoid becoming pregnant while taking psychotropic medication and to notify psychiatrist immediately upon becoming pregnant
- Documentation of beneficiary understanding of medication education
- Record reflecting that Drug Enforcement Agency-scheduled drugs are avoided in the treatment of beneficiaries with a history of substance use disorder/dependency

### **Outside Resources Documentation**

If outside resources are used for care, the following documentation must be included:

- Documentation of the use of resources outside therapeutic encounters, including appropriate preventive services, such as relapse-prevention strategies, lifestyle changes, stress management, wellness programs, and referrals to community resources
- Prompt referral of beneficiaries who become homicidal, suicidal, or unable to conduct activities of daily living to the appropriate level of care

## **Inpatient Medical Records**

All inpatient—including RTC and PHP—behavioral health records must contain the following:

- Psychiatric admission evaluation report within 24 hours of admission
- History and physical examination within 24 hours of admission (The complete report must be documented within 72 hours of acute and RTC programs and within 3 working days for PHPs.)
- Individual and family therapy notes within 24 hours of procedure for acute care, detoxification, and RTC programs, and within 48 hours for PHPs
- Preliminary treatment plan within 24 hours of admission
- Master treatment plan within 5 calendar days of admission for acute care, 10 days for RTC care, 5 days for full-day PHPs, and 7 days for half-day PHPs
- Family assessment report within 72 hours of admission for acute care and within 7 days for RTCs and PHPs
- Nursing assessment report within 24 hours of admission
- Nursing notes at the end of each shift for acute and detoxification programs, after every 10 visits for PHPs, and at least once a week for RTCs
- Physician notes daily for intensive treatment, detoxification, and rapid stabilization programs, twice per week for acute programs, and once per week for RTCs and PHPs
- Group therapy notes once per week
- Ancillary service notes once per week

Additionally, any consultations, studies, and treatments must be documented with indication of results. A statement of informed consent must also be provided for any invasive treatments.

## **Individual Provider (Office) Medical Records**

The individual provider (office) medical record must include the beneficiary's:

- Address
- Address and telephone number of at least 1 designated emergency contact
- Employer and/or school name(s)
- Guardianship information, if applicable
- Home and alternative telephone numbers
- Marital/legal status

Informed consent for evaluation, treatment, and communications signed by the beneficiary or the legal guardian should also be a part of the medical record. Each clinical entry must clearly indicate date, type of contact, practitioner's signature, and practitioner's credentials. Additionally, each medical record must contain documentation showing communication with the beneficiary's primary physician.

## Behavioral Health Care Coverage Details

Figures 6.1 through 6.3 on the following pages offer benefit summary details for covered behavioral health care services based on plan type.

**Behavioral Health Care Outpatient Services: Coverage Details**

**Figure 6.1**

<p><b>Behavioral Health Evaluation and Therapy</b></p>	<ul style="list-style-type: none"> <li>• Benefits provide up to 2 routine therapy sessions per week; more frequent visits require additional authorization.</li> <li>• Each beneficiary (except ADSMs) may self-refer for the first 8 outpatient therapy sessions per FY, (October 1–September 30) without medical necessity review or prior authorization; sessions beyond the initial self-referred 8 require medical necessity review and prior authorization. ADSMs must follow the protocol within their military treatment facilities (MTFs) for obtaining behavioral health care within the MTFs. For care outside of the MTFs, ADSMs must have referrals and prior authorizations from their primary care managers (PCMs) or, if enrolled in TRICARE Prime Remote, from their Service Points of Contact.</li> </ul> <p><b>Notes:</b></p> <ul style="list-style-type: none"> <li>• The initial 8 outpatient behavioral health care visits for covered benefits do not require a PCM/primary care provider referral; beneficiaries may self-refer. <i>(ADSMs must follow procedures as noted above.)</i></li> <li>• TRICARE Prime beneficiaries must self-refer to network providers.</li> <li>• Typical individual therapy sessions are 45-50 minutes in duration. Individual sessions of greater duration may require authorization.</li> <li>• Licensed or certified mental health counselors and pastoral counselors require physician referrals and ongoing supervision with the referring physician. A copy of the referral should be kept in the patient's chart.</li> <li>• Providers are allowed 1 initial evaluation per beneficiary per FY without authorization. It does not count as a therapy session within the initial 8 self-referred outpatient visits available to non-ADSMs. Additional evaluations in the same FY require prior authorization, regardless of whether the first 8 visits without a referral have been met.</li> </ul>
<p><b>Substance Use Disorders</b></p>	<ul style="list-style-type: none"> <li>• Benefit period begins with the first day of covered treatment and ends 365 days later.</li> <li>• Benefits provide up to 60 individual or group outpatient therapy sessions and up to 15 family therapy sessions per benefit period.</li> <li>• Services always require prior authorization.</li> <li>• Services must be rendered by TRICARE-authorized institutional providers. These providers must be either a TRICARE-authorized hospital or an organized substance use disorder treatment program in a TRICARE-authorized freestanding or hospital-based SUDRF.</li> </ul>
<p><b>Other Outpatient Services</b></p>	<ul style="list-style-type: none"> <li>• Psychological testing is generally approved up to 6 hours per year and requires a medical-necessity review and prior authorization.</li> <li>• Medication management checks do not require medical necessity review or authorization for up to 2 visits per month and do not count as therapy sessions.</li> <li>• Electroconvulsive therapy always requires medical necessity review and prior authorization.</li> </ul>

**Behavioral Health Care Inpatient Services: Coverage Details**

**Figure 6.2**

<p><b>Behavioral Health Disorder</b></p>	<ul style="list-style-type: none"> <li>• Benefits provide up to 30 days per FY, (<i>October 1–September 30</i>) or per admission for acute inpatient care for beneficiaries age 19 and older.</li> <li>• Benefits provide up to 45 days per FY or per admission for acute inpatient care for beneficiaries age 18 and younger.</li> <li>• Benefits provide up to 150 days per FY or per admission for care in TRICARE-approved residential treatment centers for beneficiaries under age 21 (<i>dependent upon facility age restrictions</i>).</li> <li>• All <b>nonemergency</b> admissions require prior authorization.</li> </ul>
<p><b>Substance Use Disorders: Acute Inpatient Care/ Detoxification</b></p>	<ul style="list-style-type: none"> <li>• Covered for complications of alcohol and drug abuse or dependency and detoxification only when the patient's condition is such that the personnel and facilities of a hospital are required.</li> <li>• Covered for up to 7 days per episode in a TRICARE-authorized facility.</li> <li>• Days count toward the 30- or 45-day behavioral health care inpatient limit.</li> <li>• All <b>nonemergency</b> admissions require prior authorization.</li> <li>• Services must be rendered by TRICARE-authorized institutional providers. These providers must be either a TRICARE-authorized hospital or an organized substance use disorder treatment program in a TRICARE-authorized freestanding or SURF.</li> </ul>
<p><b>Substance Use Disorders: Rehabilitation</b></p>	<ul style="list-style-type: none"> <li>• Benefit period starts the first day of covered treatment and ends 365 days later.</li> <li>• Benefits provide up to 21 days per benefit period (<i>combined partial and/or inpatient</i>).</li> <li>• Up to 7 days of detoxification are allowed per episode in addition to the 21 rehabilitative days.</li> <li>• Days count toward the 30- or 45-day behavioral health care inpatient limit.</li> <li>• Benefits provide up to 1 treatment episode in a 1-year period and up to 3 treatment episodes during the beneficiary's lifetime.</li> <li>• All <b>nonemergency</b> admissions require prior authorization.</li> <li>• Services must be rendered by TRICARE-authorized institutional providers. These providers must be either a TRICARE-authorized hospital or an organized substance use disorder treatment program in a TRICARE-authorized freestanding or SURF.</li> </ul>

**Behavioral Health Care Psychiatric PHPs: Coverage Details**

**Figure 6.3**

<p><b>All Partial Hospitalization Program (PHP) Services</b></p>	<ul style="list-style-type: none"> <li>• All services require medical necessity review and prior authorization.</li> <li>• A minimum of 3 hours of therapeutic services are allowed up to 5 days per week, and may include day, evening, night, and weekend programs.</li> </ul>
<p><b>Behavioral Health Disorder</b></p>	<ul style="list-style-type: none"> <li>• Benefits provide up to 60 treatment days per beneficiary, per fiscal year.</li> <li>• The 60 treatment days are not offset by or counted toward the 30- or 45-day inpatient limit.</li> <li>• Care must be provided in a TRICARE-authorized psychiatric PHP.</li> </ul>

# Health Care Management and Administration

## Referrals and Authorizations

A referral is the process of sending a TRICARE Prime patient to another professional provider for a consultation or health care service when the requested service is outside the scope of practice for the referring provider. A referral is required for most services for TRICARE Prime beneficiaries if the service is provided by a civilian provider other than the primary care manager (PCM). ADSMs must always have referrals for all care outside of a MTF, except for emergencies. The MTF must be aware of all treatment received by the ADSM to ensure that he or she remains fit for duty. Referrals are required for most services for TRICARE Prime, TPR, and TPRADFM beneficiaries, even if the service is not listed on the West Region Prior Authorization List. Referrals are not the same as authorizations.

When a TRICARE Prime beneficiary's PCM is unable to provide a specialized medical service, the PCM must request a referral from UnitedHealthcare. UnitedHealthcare approves a referral when a TRICARE Prime beneficiary needs specialized medical services from a professional or ancillary provider and the services are not available at the MTF. **The MTF is always the primary source of care for TRICARE Prime beneficiaries.** The MTF has right of first refusal (ROFR) to provide care for a TRICARE Prime beneficiary. Refer to the ROFR section of this Handbook for more information regarding ROFR.

An authorization is a request for services, a procedure, or admission to a hospital or facility that must be obtained before any service is given or within 24 hours after an emergency admission. Authorizations must be obtained prior to services being delivered for those services on the Prior Authorization List, which can be found at [uhcmilitarywest.com](http://uhcmilitarywest.com).

Referral or authorization request for all services (medical, surgical, behavioral) should be faxed to UnitedHealthcare at:

- Urgent referrals and authorizations - (877) 890-8203
- Routine referrals and authorizations - (877) 890-9309

If you are not the beneficiary's PCM and are not an ordering practitioner, you must identify the referring provider in the note field. You should not request services outside your scope of practice.

You may fax a *TRICARE Patient Referral/Authorization Form* to UnitedHealthcare (automated fax transmission or paper fax) to the assigned number. You may download either a "type & print" form that you can complete online and then print, or a form that you can print and complete by hand. Both forms are available at [uhcmilitarywest.com](http://uhcmilitarywest.com) → Find a Form → Medical/Surgical Referral/Authorization.

UnitedHealthcare staff reviews referral/authorization requests in order to:

- Determine the beneficiary's TRICARE eligibility
- Verify that the service requested is a TRICARE benefit
- Determine if the service is medically necessary and is at the appropriate level of care
- Determine if the service requested can be provided by an MTF and send the beneficiary to the MTF, if available
- Locate a network civilian provider (If a network provider cannot be located, a non-network provider may be authorized.)
- Notify the beneficiary, the servicing provider, and the requesting provider that the referral has been completed

The review process is expedited when referral/authorization requests include all information required and the faxed *TRICARE Patient Referral/Authorization Form* is completed in a legible manner.



UnitedHealthcare determines whether the request can be processed or if additional information is required. Network providers must be used if available. Non-network providers will not be authorized without review.

## UnitedHealthcare Military & Veterans Prior Authorization Requirements

### Note:

• **Other Health Insurance (OHI):** When a beneficiary has “other insurance” that provides primary coverage, the following preauthorization requirements do not apply (except for Solid Organ and Stem Cell Transplants and ECHO services). Any medically necessary reviews UHC M&V believes are necessary, to act as a secondary payor, shall be performed on a retrospective basis.

• **Active Duty Service Members (ADSM):** All civilian care requires prior approval from the ADSM’s Service Point of Contact (SPOC) which is their assigned Primary Care Manager (PCM) within Military Treatment Facility (MTF) or for TRICARE Prime Remote ADSMs, the Military Medical Support Office (MMSO). Please follow the UHC M&V Referral and Authorization request and inpatient admission notification processes as outlined in the TRICARE Provider Handbook found online at [uhcmilitarywest.com](http://uhcmilitarywest.com).

Procedures & Services	Place of Services	Explanation
<b>Adjunctive Dental</b>	All	Adjunctive dental care is that dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition; or is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease.  Inpatient admissions related to adjunctive dental services, prior authorization must be received within 24 hours of the admission.
<b>Behavioral Health</b>	Inpatient	Applies to preadmission and continued stay for non-emergency inpatient services and all care in a partial hospitalization program and includes: <ul style="list-style-type: none"> <li>• Substance Abuse Rehabilitation</li> <li>• Residential Treatment Center</li> </ul>
<b>Behavioral Health</b>	Outpatient	Applies to the following services: <ul style="list-style-type: none"> <li>• Mental health care after the 8th visit per benefit year. Primary Care Manager (PCM) referral not required. Note: <i>Active Duty Service Members (ADSMs) require preauthorization prior to receiving mental health service.</i></li> <li>• Medication Management exceeding 2 times per month</li> <li>• Psychoanalysis</li> <li>• Psychotherapy after the initial 8 outpatient visits</li> <li>• All psychological and neuropsychological testing</li> <li>• Behavioral health interpretation or explanation of results (collateral visits)</li> <li>• ECT procedures</li> </ul>
<b>Drugs &amp; Biologicals</b>	All	A drug capable of being injected intravenously, through an intravenous infusion, subcutaneously or intra-muscularly  Includes drugs and biologicals for certain chemotherapy drugs and injectables/ infusion therapy delivered in the home.
<b>Durable Medical Equipment (DME) - greater than \$2000</b>	Outpatient	DME with <b>a retail purchase cost or a cumulative rental cost</b> over \$2,000.00 <ul style="list-style-type: none"> <li>• Rental for all DME categorized by Centers for Medicare and Medicaid Services (CMS) as capped rentals.</li> </ul>
<b>Extended Health Care Options (ECHO) services</b>	All	The Extended Care Health Option (ECHO) is a supplemental program to the basic TRICARE program. ECHO provides financial assistance for an integrated set of services and supplies to eligible active duty family members (including family members of activated National Guard or Reserve members).
<b>Hearing Services</b>	All	<b>All hearing services</b>
<b>Home Health Care Services</b>	Outpatient	All services which are based in the home including, but not limited to home infusion

<b>Procedures &amp; Services</b>	<b>Place of Services</b>	<b>Explanation</b>
<b>Hospice</b>	All	Hospice is a type of care and a philosophy of care that focuses on the palliation of a terminally ill or seriously ill patient's symptoms
<b>Hyperbaric Oxygen Treatment</b>	All	Non-emergent hyperbaric oxygen treatments
<b>Inpatient Admissions &amp; Services</b>	Inpatient	Inpatient admissions related to the following services: <ul style="list-style-type: none"> <li>• Cancer care trials</li> <li>• Dental anesthesia and institutional benefit</li> <li>• Prior Authorization of inpatient facility admissions within 24 hours of the admission</li> <li>• Prior Authorization of discharge from facilities by within 24 hours of the discharge</li> <li>• Continued stay review for inpatient admissions for all behavioral health care, surgical and other listed services above or upon request by UnitedHealthcare.</li> <li>• Admissions or transfers from inpatient setting to skilled nursing facility, acute rehabilitation and long term acute care (LTAC)</li> <li>• Bariatric surgery</li> <li>• Medically necessary cosmetic, reconstructive and plastic surgery</li> <li>• All solid organ and stem cell transplants</li> <li>• Also see Behavioral Health sections for additional requirements</li> </ul>
<b>Laboratory Developed Tests (LDT)</b>	All	Laboratory developed tests (LDT) are identified by Food and Drug Administration (FDA) regulation as a medical devices requiring FDA premarket clearance or premarket approval to be eligible for cost-sharing by TRICARE. Myriad and Genomics Health Only.
<b>Non-Emergent Transport Services</b>	All	Non-urgent ambulance transportation (by air, land, other) between specified locations.
<b>Non-Network Provider Services</b>	All	A referral from a network physician, or health care provider to a hospital, physician, or other health care provider who is not contracted with UnitedHealthcare or a Military Treatment Facility
<b>Biofeedback</b>	All	Biofeedback is a complementary and alternative medicine technique to learn to control bodily functions using your mind.
<b>Preservation of Stem Cells</b>	All	Stem cell preservation is the gathering and saving of nutrient rich stem cells that are present in the body, especially the umbilical cord at birth.
<b>Prosthetics</b>	All	Prosthetics is an artificial device extension that replaces a missing body part. Prostheses are typically used to replace parts lost by injury (traumatic) or missing from birth (congenital) or to supplement defective body parts.
<b>Rehabilitation: Occupational, Physical &amp; Speech Therapy</b>	Outpatient	Outpatient rehabilitation services, when provided by a licensed physical therapist, licensed occupational therapist, licensed speech therapist
<b>Smoking Cessation</b>	Outpatient	Smoking cessation counseling for third quit attempt in a 12-month period

### **Referral and Appointment Process**

The beneficiary will be notified via letter, email, or text message to log into the secure beneficiary website to schedule his or her own appointment with the specialist. The letter is mailed within 1 business day of approval and includes:

- Requesting provider's name
- UnitedHealthcare reference number
- MTF tracking number (If a request is from a civilian provider, there is no MTF order number.)
- Specialist's name, office address, and office telephone number
- Time frame in which the appointment must be obtained by the beneficiary
- Instructions to notify UnitedHealthcare of the appointment date either by calling (877) 988-WEST/(877) 988-9378 for UnitedHealthcare's IVR system, by email, or by fax (These instructions do not apply to all referrals and authorization requests.)

- Reminder to take a copy of the referral/authorization approval letter, any pertinent medical records, a list of current medications, and any available x-rays or test results to the appointment with the specialist
- Reminder that the beneficiary can track the status of his or her referral or authorization request online, if registered at [uhcmilitarywest.com](http://uhcmilitarywest.com)

Beneficiaries have the right to choose a different servicing provider by contacting UnitedHealthcare. The approved servicing provider should wait for the beneficiary to call to make an appointment.

Unless otherwise stated on the approval letter, a referral is valid for 180 calendar days from the date of issuance and is subject to TRICARE eligibility. Issuance of a referral does not guarantee payment by TRICARE. If the beneficiary needs specialty care within 72 hours or less, or for an urgent issue, the appointment process must be expedited from provider to provider. When providers expeditiously arrange appointments, it is still necessary for the PCM to complete the referral form process so a tracking number can be issued.

Note: In the case of an urgent or emergency request, no approval letter is sent to the beneficiary. However, a copy of the approval letter is still faxed or mailed to the requesting provider's office.

Providers who are registered users at [uhcmilitarywest.com](http://uhcmilitarywest.com) may check the status of referral/authorization requests online, view the documentation submitted by the requesting provider, and view the letter that is faxed or mailed from UnitedHealthcare.

Note: Beneficiaries may also register for the secure website to check the status of their referral/authorization requests. It is possible that a beneficiary may learn the status of his or her request before the referring and servicing providers receive the faxed approval letter from UnitedHealthcare.

### **Requesting Additional Services**

When requesting additional services, the *TRICARE Patient Referral and Authorization Form* may be used. The form is available at [uhcmilitarywest.com](http://uhcmilitarywest.com) → Find a Form → Medical/Surgical Referral/Authorization.

TRICARE Prime, TPR, and TPRADFM beneficiaries are required to have a referral from their PCM or an MTF for most specialty care services. If there is no referral from a PCM or the MTF to the civilian specialty provider within 180 days (or the time period noted in the initial referral) of the request for services submitted by that civilian specialty provider, the request will not be approved. When the care is not approved, the beneficiary, the requesting civilian specialist, and the PCM will receive a notification from UnitedHealthcare stating the beneficiary must contact his or her PCM or MTF and obtain a specialty referral that needs to be processed by UnitedHealthcare before receiving additional specialty care.

**This is not a denial of service**, but if the beneficiary does not seek prior approval from the PCM or MTF and receives specialty services, then the services may be covered under the POS option, resulting in higher out-of-pocket expenses for the beneficiary.

To determine whether the PCM or the servicing provider should request the referral or authorization, follow these guidelines:

- If the additional services required are for the same diagnosis as the initial referral to that specialist and there is a PCM referral for this diagnosis within the last 180 days (or the time period noted in the initial referral), the specialist can request the referral to a second network specialist. Note that the request will still be subject to ROFR if the MTF has the capability to provide those services.
- If it is not the same initial diagnosis, a TRICARE Prime beneficiary needs to be directed back to his or her PCM.

- If the MTF can provide ancillary services, such as magnetic resonance imaging (MRI) or physical therapy services, then the MTF must review the request for ROFR determination. (See the *ROFR* section of this Handbook for more information on ROFR.)

Please review the following examples:

- A TRICARE Prime beneficiary is referred to a cardiologist by his or her PCM within the last 180 days (or the time period noted in the initial referral). The cardiologist determines that cardiovascular surgery is necessary. The cardiologist submits a request to UnitedHealthcare for a referral to a cardiovascular surgeon. The cardiologist's consult report would indicate the need for a second specialist. The consult report would keep the PCM aware of the need for a second specialist and the beneficiary's condition, but there is no need for the beneficiary to return to his or her PCM to obtain the referral. The referral would be subject to ROFR if the MTF has the capability to provide the cardiovascular surgery.
- A TRICARE Prime beneficiary is referred to a cardiologist by his or her PCM. The cardiologist determines during the consultation that the beneficiary has tested positive for type 2 diabetes, which requires the services of an endocrinologist or the PCM. In this case, the beneficiary should be directed back to the PCM who will either manage the care or request a referral from UnitedHealthcare for the appropriate specialty.
- A TRICARE Prime beneficiary is referred to an orthopedist by his or her PCM and it is determined that the beneficiary needs to have an MRI and physical therapy. The orthopedist requests the additional referral from UnitedHealthcare. UnitedHealthcare will forward the request to the MTF to determine if it can provide the care or service. If the MTF can provide the requested services, the beneficiary will be approved to receive the services at the MTF.

Providers should review the letter from UnitedHealthcare, which is also available online, that is sent in response to the referral or authorization request.

The letter will provide the date range for which services have been approved. If services cannot be provided within that date range, a new referral from the PCM or MTF is required to avoid higher out-of-pocket costs for the beneficiary and potential delays in care.

For additional information on the referral process, go to [uhcmilitarywest.com](http://uhcmilitarywest.com) → Referrals and Authorizations.

### **Checking Referral and Authorization Status Online**

Providers may check the status of referrals and authorizations in the secure area of the UnitedHealthcare website. Access to this feature is available only to providers who have registered on [uhcmilitarywest.com](http://uhcmilitarywest.com). Providers may view the status of referrals and authorizations that they have requested and for which they are the servicing provider.

The information available includes the beneficiary's information, the date the request was received by UnitedHealthcare, services requested and their status, and more. Servicing providers may also view the original request submitted by the referring provider to UnitedHealthcare.

### **Prior Authorization**

The request for certain medical, surgical, and behavioral health care services is reviewed to confirm medical necessity and appropriateness of care prior to services being rendered or within 24 hours of an emergency admission. Refer to [uhcmilitarywest.com](http://uhcmilitarywest.com) for the current Prior Authorization List, which lists all services requiring prior authorization. A prior authorization is required for requested services, procedures, or admissions that require medical necessity review prior to services being rendered. Specialists are required to obtain authorizations before performing any procedure for a TRICARE Prime beneficiary.

The Prior Authorization List is available online at [uhcmilitarywest.com](http://uhcmilitarywest.com). This online list has a link to a list of codes that require authorization. The frequency of updates for this list of codes varies (as frequently as monthly) as new codes are approved for industry use and as updates are made to the No Government Pay Procedure Code List, which is available at [www.tricare.mil/nogovernmentpay](http://www.tricare.mil/nogovernmentpay).

Authorizations are required for all procedures listed on the Prior Authorization List for all TRICARE beneficiaries in programs administered by UnitedHealthcare, including TRICARE Prime, TPR, TPRADFM, TRICARE Standard and TRICARE Extra, TRS, TRR, TYA, and ECHO. Providers must submit authorization requests with supporting clinical documentation for these services. When using the fax process, please include the clinical information along with the *TRICARE Patient Referral/Authorization Form*.

### **Prior Authorization Not Required**

The following is a partial list of services that do not require authorization:

- Annual Pap smear
- Cardiac stress tests and myocardial imaging
- Colonoscopy—screening and diagnostic
- CT scans (Screening is not covered.)
- Dexa scans (Screening is not covered.)
- DME not on the Prior Authorization List
- 8 routine outpatient behavioral health visits per beneficiary, per fiscal year (See the *Behavioral Health Care Services* section of this Handbook for additional details.)
- Emergency room services
- Esophagogastroduodenoscopy
- Eye examinations
- Intravenous pyelogram
- Labs (except for genetic testing, which requires authorization)
- Mammograms—annually for women beginning at age 40 (Covered annually beginning at age 30 for women who have a 15% or greater lifetime risk of breast cancer. For more information, see “Covered Services” in the *Medical Coverage* section of this Handbook.)
- Pulmonary function test
- Radiographs
- Ultrasounds—only covered if medically necessary (Screening to determine the baby’s sex is not covered.)
- Upper gastrointestinal

### **Prior Authorization for ADSMs**

For ADSMs, referrals from the MTF or MMSO and prior authorizations are required for all inpatient and outpatient services from a civilian network or non-network provider. This is to ensure ADSMs continue to meet fitness-for-duty requirements. Providers who do not obtain a prior authorization when one is required, or who exceed the scope of an approved prior authorization, risk having payment for the service reduced or denied.

### **Prior Authorization for TRICARE Standard and TRICARE Extra Beneficiaries**

Providers treating TRICARE Standard and TRICARE Extra beneficiaries are required to obtain authorization before performing the procedures on the Prior Authorization List available online at [uhcmilitarywest.com](http://uhcmilitarywest.com).



Prior authorization from TRICARE is not required when the beneficiary has OHI that covers the treatment required, except as indicated in Figure 8.12 in the *Claims Processing and Billing Information* section of this Handbook. If the OHI does not cover a service or procedure that TRICARE does cover, submit a statement from the OHI indicating that the OHI does not cover the service along with your request to UnitedHealthcare. This will help prevent delays.

### **Avoiding Referral/Prior Authorization Request Delays**

The following guidelines will help expedite your referral and authorization requests:

- Use the *TRICARE Patient Referral/Authorization Form* for any TRICARE Prime beneficiary requiring a specialty care referral or a prior authorization for any TRICARE West Region beneficiary who requires prior authorization for services on the Prior Authorization List.
- Fax referral and authorization requests with physician documentation and all clinical indications, including laboratory/radiology results related to the requested service. Attach relevant documentation to your fax request. Submit a complete and legible *TRICARE Patient Referral/Authorization Form* by fax.
- Be specific about the requested services and provide the most appropriate procedure and diagnosis codes. Requests for DME also require complete information on applicable codes. A reasonable range is acceptable. Include National Drug Codes for medication requests.
- For dates of service prior to October 1, 2014, make sure the correct ICD-9 and Current Procedural Terminology (CPT®) code(s) are included. For dates of service on or after October 1, 2014, make sure the correct ICD-10 code is included. Include clinical documentation for services on the Prior Authorization List. Be sure to clearly reference your contact information, particularly the fax number to which UnitedHealthcare should respond. Incomplete forms may slow the process.
- Use relevant clinical information forms, available on [uhcmilitarywest](#) → Find a Form → Clinical Information to assist you in providing the necessary information for UnitedHealthcare to process your requests.
- Pictures sent via fax do not transmit clearly and may delay the process while UnitedHealthcare requests and awaits receipt of originals. If you mail hard copies of photographs and wish to have them returned to your office after the authorization is approved, please indicate so when you mail the photographs to UnitedHealthcare. Otherwise, after the requested procedure is approved, the mailed photos may be destroyed.
- Generally, approvals are active for 180 days, unless otherwise indicated on the referral/authorization approval letter. If the servicing provider is unable to provide the approved services prior to the expiration of the referral, a new referral/authorization request must be submitted. After 180 days (or the time period noted in the initial referral), the PCM must request a new referral/authorization. If the specialist has obtained a referral from the PCM within 180 days, the specialist may make the request for services related to the same diagnosis. If the servicing provider wishes to add additional procedural or treatment codes to the approved referral or authorization, then a new referral/authorization request must be submitted covering the additional requested services.
- Verify the beneficiary's demographic information (e.g., sponsor's SSN or DBN, or DoD identification number, address, date of birth) and include it on the request form.
- When faxing, you only need to fax your referral or authorization request once, if you have confirmed that you faxed the referral to the correct number and have a confirmation from your fax machine. Re-faxing creates duplicate requests and delays processing. You may check the status of your request online at any time if you are registered with [uhcmilitarywest.com](#).



- When faxing, sending batches of completed *TRICARE Patient Referral/Authorization Forms* is permitted. Please note, sending multiple requests under 1 fax cover sheet may increase the processing time.
- Approved referrals are faxed to provider offices between midnight and 3:00 a.m. daily. It is important to leave (secure) fax machines on after hours to provide for the prompt receipt of authorizations from UnitedHealthcare. You may also obtain the status of services for which you are the approved servicing provider 24 hours a day, 7 days a week online if you are registered with [uhcmilitarywest.com](http://uhcmilitarywest.com).
- Remember to submit the CPT or Healthcare Common Procedure Coding System (HCPCS) codes for services requested. Experience shows that additional services are commonly requested, subsequent to the initial request. In such cases, more services may be approved than requested; providers should only provide medically necessary services.

**For requesting providers:** If you have not received confirmation of the referral or approval of the authorization, please assure your patients that medically necessary covered benefits will be authorized and reimbursed.

**For providers receiving referrals/authorizations directly from the Requesting Provider:** If you receive communication from the requesting provider that the referral or authorization has been submitted, please wait for the confirmation that the service has been approved as a covered benefit. All medically necessary and covered benefits for eligible beneficiaries will be authorized and reimbursed. You may check the status of services for which you are the requested servicing provider online if you are registered with [uhcmilitarywest.com](http://uhcmilitarywest.com).

Note: Prior authorization is not a guarantee of payment.

### **ECHO Prior Authorization**

Providers must request prior authorization for all ECHO services. Refer to the [TRICARE Program Options](#) section of this Handbook for more information about the ECHO program.

### **UnitedHealthcare Penalties for Non-compliance**

#### **Network Providers**

TRICARE claims submitted to PGBA without the required authorization are reviewed and, if determined to be medically necessary and for a covered benefit, reimbursed at the TRICARE-allowable charge with an assessed penalty. Providers may not bill the beneficiary the penalty amount. If the beneficiary did not advise the provider of TRICARE coverage before services were rendered, the provider may request a post-service, prepayment review from UnitedHealthcare. The request and related information/documentation may be submitted to:

TRICARE West Region  
Correspondence Department  
P.O. Box 7065  
Camden, SC 29020 -7065

#### **Non-Network Providers**

TRICARE claims submitted to PGBA without the required authorization are denied.

### **Medical Necessity Review Requirements**

A TRICARE beneficiary may need a procedure that requires a medical necessity review. A medical necessity review determines if the procedure requested is the appropriate and necessary treatment for the beneficiary's illness or injury according to accepted standards of medical practice and TRICARE policy. All TRICARE providers in nonemergency settings are required to obtain an authorization for procedures included on the Prior Authorization List. Providers may access the Prior Authorization List at [uhcmilitarywest.com](http://uhcmilitarywest.com).

The Prior Authorization List is subject to change. The specific codes requiring prior authorization are also subject to change.

Note: Prior authorization is not a guarantee of payment.

### **Referrals, Authorizations, and OHI**

Referrals and authorizations are not required for TRICARE-covered procedures when the beneficiary has OHI that covers the rendered service, except as indicated in Figure 8.12 in the *Claims Processing and Billing Information* section of this Handbook. For example, even if the beneficiary has OHI, authorization is required for any behavioral health treatment outside of the initial 8 self-referred visits per fiscal year. See the *Behavioral Health Care Services* section of this Handbook for more information.

All of the following apply when a TRICARE beneficiary has OHI:

- The procedure must be a covered benefit of the OHI, and all of the rules of the primary insurance must be followed; otherwise, TRICARE does not participate in the claim.
- Uniformed service members receiving care under TPR or the Supplemental Health Care Program (see the *TRICARE Program Options* section of this Handbook) are not subject to coordination-of-benefit rules.

See the *Claims Processing and Billing Information* section of this Handbook for more information about coordinating benefits between TRICARE and OHI. TRICARE is always the primary payer for ADSMs.

### **Consult Report Tracking**

Providers must submit their specialist reports (e.g., consultation reports, discharge summaries, operative reports, therapy reports, imaging study reports, reports regarding any additional procedures or skilled therapies, final reports) to the referring provider or MTF within 30 working days of the specialty encounter. Preliminary reports for urgent and emergency services are due within 24 hours, and the final report is due within 10 working days. The intent is to facilitate appropriate continuity of care for all TRICARE beneficiaries. Both civilian and MTF referring providers need feedback to properly manage their patients' care. For Active Duty Service members, this will be shared with the MTFs and MMSO to assist them in assuring that the Active Duty Service members are ready for duty.

Providing consult reports improves quality of care for patients. It also improves coordination of care between the MTF and civilian providers. Having a complete medical record is necessary for the military to assess troops' combat readiness and fitness for duty.

### **Report Tracking Procedures for Referrals**

Approved referrals will be entered into UnitedHealthcare's medical management system. Approval notifications will be sent to the beneficiary, the PCM, and the specialist.

The beneficiary approval letter contains:

- Information on the service(s) approved
- A tracking number
- The name and contact information of the specialist
- Instructions to notify UnitedHealthcare of the appointment date

The fax to the specialist includes a copy of the beneficiary letter, the referral/authorization approval letter, and the fax cover sheet.

If you must mail your report, mail it to the referring provider, which includes the referring MTF, and fax cover sheet. This will aid in the process of sending reports to the referring provider and placing reports in the beneficiary's medical record in a timely manner.

## Report Tracking Follow-Up Process

Each MTF in the region will be following up to collect consult reports. It is imperative for the provider of the service to comply and submit the report to the MTF within 10 business days after the visit and upon contact from the MTF requesting the consult report.

## Providing Care to Beneficiaries from Other Regions

### Emergency and Urgent Care

Under all TRICARE programs, no referrals or authorizations are required for TRICARE beneficiaries receiving emergency care in or out of their TRICARE regions. However, TRICARE Prime beneficiaries are instructed to contact their PCMs or regional contractors (e.g., UnitedHealthcare; Health Net Federal Services, LLC; Humana Military Healthcare Services, Inc.) within 24 hours of an inpatient admission or the next business day to coordinate ongoing care.

TRICARE Prime beneficiaries must receive referrals from their PCMs or regional contractors for urgent care. If a TRICARE Prime beneficiary does not receive a referral, the claim will be paid under the *POS* option. If you provide emergency or urgent care services to a TRICARE beneficiary from a different region, the beneficiary will be responsible for payment of the applicable copayment or cost-share, and you will submit claims to the region where the beneficiary is enrolled, not the region in which he or she received care. See the *Claims Processing and Billing Information* section of this Handbook for more information.

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 POS option for TRICARE Prime beneficiaries. Exceptions are made if the beneficiary was referred to the emergency department by his or her PCM or regional contractor.

If you have questions about processing claims for beneficiaries from other regions, contact UnitedHealthcare at (877) 988-WEST/(877) 988-9378.

### Routine Care

TRICARE beneficiaries are instructed to receive all routine care, when possible, from network providers in their designated regions. However, in some cases, beneficiaries will receive routine care in another region. In such cases, the following guidelines apply:

- TRICARE Standard beneficiaries will pay applicable cost-shares, and providers will submit claims to the region where the beneficiary resides, not the region in which he or she received care.
- TRICARE Prime beneficiaries will receive referrals from their PCMs or regional contractors for out-of-region care and will pay applicable copayments. Providers will submit claims to the region where the beneficiary is enrolled, not the region in which he or she received care. See the *Claims Processing and Billing Information* section of this Handbook for more information. If a TRICARE Prime beneficiary does not receive a referral for out-of-region care, claims will be paid under the POS option.

If you have questions about processing claims for beneficiaries from other regions, contact UnitedHealthcare at (877) 988-WEST/(877) 988-9378.

## Medical Records Documentation

Providers must maintain clinical and other records related to individuals for whom payment was made for services rendered by the provider, or otherwise under arrangement, for a minimum of 60 months from the date of service, or the longer period specified in your agreement or by state law.

UnitedHealthcare may review your medical records on a random sample basis to evaluate patterns of care and compliance with performance standards. Policies and procedures should be in place to help ensure that a beneficiary's chart is appropriately organized and that confidentiality of the beneficiary's information is maintained. The medical record must be kept current, and must substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment.

Providers must also permit access by Deputy Director, TMA, or his designee to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state, private agencies or organizations.

### **Guidelines for Medical/Surgical Care**

The following guidelines will assist you in documenting medical and surgical care in every individual patient record:

- The record should be legible to someone other than the writer.
- Every page in the record must contain the beneficiary's name or ID number.
- Personal/biographical data should include address, employer, home and work telephone numbers, and marital status.
- All entries in the medical record must contain author ID, which may be a handwritten signature, unique electronic identifier, or initials.
- All entries must be dated.
- Significant illnesses and medical conditions must be indicated on a problem list.
- Medication allergies and adverse reactions, if any, should be prominently noted in the record.
- Medical history (for beneficiaries seen 3 or more times) should be easily identifiable and include serious accidents, operations, and illnesses.
- For children and adolescents (age 18 and younger), medical history should relate to prenatal care, birth, operations, and childhood illnesses.
- For beneficiaries age 12 and older who have been seen 3 or more times, information concerning use/abuse of cigarettes, alcohol, and controlled substances should be noted.
- Histories and physicals should contain appropriate subjective and objective information for presenting complaints.
- Laboratory and other studies should be ordered, as appropriate, and documented properly.
- Working diagnoses should be consistent with findings.
- Treatment plans should be consistent with diagnoses.
- Encounter forms or notes should include a notation, when indicated, regarding follow-up care, calls, or visits, and the specific time of return should be noted in weeks, months, or "as needed."
- Unresolved problems from previous office visits should be addressed in subsequent visits.
- Reviews should be conducted for underutilization or overutilization of consultants.
- Consultant notes/results for a requested consultation must be entered on the chart.

- To signify review, all consultation, laboratory, and imaging reports filed in the chart should be initialed by the ordering practitioner. Review and signature by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, review by the ordering practitioner should be documented.
- Consultation, abnormal laboratory, and imaging study results should include an explicit notation of follow-up plans in the record.
- Individual records must be used to demonstrate whether the care was needed and if it was of such quality to meet the beneficiary's needs.
- Immunization records for children must be up to date, and an appropriate history must be made in the medical records for adults.
- Evidence that preventive screening and services were offered and accepted or rejected in accordance with the office's practice guidelines should be included in the record.
- In cases of unusual deaths, or in deaths of medical-legal and educational interest, there should be documentation of request (consent or refusal) for an autopsy.
- Medical record documentation of injection(s) should include:
  - › Name of drug
  - › Lot number
  - › Time of administration
  - › Dosage
  - › Route of administration
  - › Site of injection
  - › Signature or initials of individual administering the medication
  - › For immunizations: lot number, manufacturer, verification that the *Vaccine Information Statement* was given to the patient or parent/guardian, and the name and address of the health care provider administering the vaccine

### **Guidelines for Medical/Surgical Care Specialists**

A provider may refer a TRICARE beneficiary to a specialist to obtain an opinion, advice, or specialty care services. In the case of a beneficiary enrolled in TRICARE Prime, a referral must be obtained from UnitedHealthcare. The specialist's treatment or findings, along with results of any services rendered, must be documented in the beneficiary's record.

Note: To help promote continuity of care, all TRICARE network specialty providers are responsible for communicating the results of an examination and/or treatment to the referring civilian or military provider, who is usually the beneficiary's PCM, within 10 working days. For more information, refer to "[Consult Report Tracking](#)" earlier in this section.

### **Inpatient Admission Notification**

Providers are required to notify UnitedHealthcare within 24 hours of an emergency admission. Medical/surgical admission and maternity notifications should be faxed with face sheets to (877) 578-2738. This also applies to weekend notifications. Notification of outpatient observation is not required.

## Utilization Management

Utilization Management is a process of prospective, concurrent, or retrospective reviews that evaluate the medical necessity and appropriateness of beneficiary medical care.

### Prospective Review

Prospective review is conducted when a certain procedure or service requires a medical necessity review. The review is performed under the direction of a registered nurse, physician assistant, behavioral health clinician, or physician, and its purpose includes the following:

- Determining medical necessity
- Evaluating proposed treatment
- Assessing level of care required
- Determining appropriate level of care prior to admission
- Identifying potential for discharge-planning needs and determining whether the case meets care-coordination or case-management criteria
- Identifying potential quality-of-care issues

Note: First-level reviewers may issue denial determinations based on coverage limitations contained in 32 Code of Federal Regulations (CFR) 199, the *TRICARE Policy Manual*, and other TRICARE guidance (these are considered factual determinations) or refer the case to second-level review. Physicians who did not participate in the first-level review of the care under consideration conduct second-level reviews.

### Concurrent Review

Concurrent review is a process of continual reassessment of the beneficiary's needs during an inpatient stay. Concurrent review activities monitor the patient for appropriate level of care and identify potential care coordination, demand management, discharge needs, and case-management candidacy.

The care coordinator responsible for concurrent review evaluates the beneficiary's level-of-care needs during hospitalization.

Based on medical determinations of levels of assistance that may be required, an entire episode of medical care may be adapted to fit the beneficiary's status and needs. Components may include:

- A continuum of health care based on identified needs and goals
- Design and adaptation of health care initiatives for the beneficiary
- Identification of assistance needs throughout an entire episode of care
- Beneficiary and family education

### Retrospective Review

A retrospective review is a review of the beneficiary's medical record that occurs after the services have been rendered. The review may be performed as part of the quality-management process or during the claims verification.

Diagnosis-related group (DRG) validation is conducted on a 1% sample of DRG-reimbursed claims. Cases by facilities are randomly reviewed and audited. The complete medical record is requested for verification of level of care determination, verification of diagnostic and procedural coding, and validation of appropriate reimbursement for the claim. Technical denials are issued when complete medical records are not received within 30 days. Payment adjustments are made when errors are identified during the DRG-validation audit.



## Review Activities - Institutional Providers

With regard to institutional network provider only, the TRICARE program requirements specify the following:

Institutional providers must cooperate with UnitedHealthcare in the assumption and conduct of review activities, allocate adequate space for the onsite review, and photocopy and deliver to UnitedHealthcare all of the required information within 30 calendar days of a request for an off-site review. UnitedHealthcare shall reimburse the provider for the costs of photocopying and postage using the same reimbursement as Medicare.

Institutional providers must inform UnitedHealthcare within 3 working days if they issue a notice that the beneficiary no longer requires inpatient care. They will assure that each case subject to preadmission or preprocedure review has been reviewed and approved by UnitedHealthcare.

Institutional providers will provide all beneficiaries, in writing, their rights and responsibilities (e.g., “An Important Message from TRICARE” and “Hospital Issued Notice of Noncoverage”).

If an institutional providers fails to obtain the required certification, they then accept full financial liability for any admission subject to preadmission review that was not reviewed, and is found to be medically unnecessary or provided at an inappropriate level.

## Care Coordination

Care coordination is a comprehensive method of assessment designed to identify beneficiary vulnerability, needs, and goals that results in the development of an action plan to produce an outcome that is desirable for the beneficiary. The goal is to provide patient advocacy, a system for coordinating client services, and a systematic approach to evaluation of the effectiveness of the beneficiary’s health maintenance.

TRICARE West Region care coordination identifies and assists TRICARE beneficiaries with post-service needs.

The care coordination process is monitored through concurrent review activities, which assess and identify potential care coordination, demand management, discharge needs, and case management candidates.

## TRICARE Quality Monitoring Contractor

KePRO is the TRICARE Quality Monitoring Contractor (TQMC) and will assist DoD Health Affairs, the TMA, MTF market managers, and the TRICARE Regional Offices by providing the government with an independent, impartial evaluation of the care provided to beneficiaries within the MHS. The TQMC will review care provided by TRICARE authorized/certified providers in addition to other TRICARE contractors and subcontractors on a limited basis. The TQMC is part of TRICARE’s Quality and Utilization Peer Review Organization Program, in accordance with 32 CFR 199.15. Providers may contact KePRO by any of the following means:

<b>Mail</b>	KePRO ATTN: TRICARE Operations 777 East Park Drive Harrisburg, PA 17111
<b>Phone</b>	(877) 841-6413
<b>Email</b>	tricare@kepro.com

Medical records will be requested from the regional contractor on a monthly basis to comply with requirements detailed in the *TRICARE Operations Manual*, Chapter 7, Section 3 at <http://manuals.tricare.osd.mil>. Your facility may be required to submit records to meet those requirements. Should you receive a request letter, you are required to submit the entire medical record that was requested. Failure to do so will result in recoupment of payment for the hospitalization and/or any other services for which you were paid in accordance with 32 CFR 199.4(a)(5).

## Clinical Quality Management (CQM)

UnitedHealthcare has established the Clinical Quality Management Program (CQMP) to develop, recommend, implement, and continuously evaluate the continuum of the medical, surgical, and behavioral health care services delivered to TRICARE-eligible beneficiaries. The CQMP is designed to identify areas where care can be improved and to provide feedback to physicians and providers in such areas as:

- Providers' clinical performances
- Practice patterns
- Eligibility for retention in the network
- Availability aspects of service delivery

UnitedHealthcare reviews network and non-network providers when evaluating the delivery of health care services. This process includes identifying potential quality-of-care issues, identifying opportunities for improvement, and implementing corrective action plans. UnitedHealthcare reviews physicians and other providers to assess quality and cost efficiency of the health care services provided.

### Provider Participation

Providers are required to participate in CQM activities in accordance with federal laws. TRICARE providers must agree to follow all established quality assurance procedures; that is, they must make medical and other pertinent records available to UnitedHealthcare.

Activities that are related to the CQM process include, but are **not** limited to:

- Participating in the investigation of grievances
- Providing access to data for quality studies
- Complying with peer review, utilization review, and quality programs and procedures established by UnitedHealthcare or TRICARE, including:
  - › Concurrent reviews
  - › Retrospective reviews
  - › Discharge planning for inpatient admissions
  - › Referral requirements (See "Referrals and Authorizations" earlier in this section.)
  - › Allowing UnitedHealthcare and its designees to have access to provider records within a reasonable time
  - › Participating in audits regarding performance assessments of provider practices

### Potential Quality Issue Review

The UnitedHealthcare CQMP oversees all care delivered under the TRICARE program and is required, at a minimum, to assess every medical record reviewed for any purpose and any care managed, observed, or monitored on an ongoing basis for potential quality indicators in accordance with the following:

- Inpatient stays
- Medical or surgical visits
- Behavioral health facility
- Office visits
- Skilled nursing

UnitedHealthcare will categorize potential quality-of-care issues using the following categories:

***National Quality Forum's Serious Reportable Events***

- Surgical or invasive procedure events
- Product or device events
- Patient-protection events
- Care-management events
- Environmental events
- Radiologic events
- Potential criminal events

***Agency for Healthcare Research and Quality Patient Safety Indicators***

- Complications of anesthesia
- Death in low-mortality DRGs
- Decubitus ulcer
- Failure to rescue
- Foreign body left during procedure
- Iatrogenic pneumothorax
- Selected infections due to medical care
- Postoperative hip fracture
- Postoperative hemorrhage or hematoma
- Postoperative physiologic and metabolic derangements
- Postoperative respiratory failure
- Postoperative pulmonary embolism or deep vein thrombosis
- Postoperative sepsis
- Postoperative wound dehiscence
- Accidental puncture or laceration
- Transfusion reaction
- Birth trauma—injury to neonate
- Obstetric trauma—vaginal with instrument
- Obstetric trauma—vaginal without instrument
- Obstetric trauma—cesarean delivery

***Deviation from Standard Practice Guidelines***

- Inefficient care
- Quality of care

Providers may be contacted regarding a potential quality issue.

If you become aware of a potential quality issue while providing care to a TRICARE beneficiary, report the issue to UnitedHealthcare by completing a *Quality Management Potential Quality Issue Referral* form available on [uhcmilitarywest.com](http://uhcmilitarywest.com) → Beneficiary → Find A Form → Clinical Programs.

### **On-Site Provider Reviews**

As part of UnitedHealthcare's CQMP, UnitedHealthcare may conduct on-site evaluations of providers who have been targeted for further evaluation based on performance indicators. UnitedHealthcare may assist the provider in the development of an action plan to correct the area of concern.

### **Confidentiality**

In accordance with federal law, all UnitedHealthcare employees who are engaged in CQM activities are required to maintain the confidentiality of information with which they deal. Individual practitioners or beneficiaries are to be referred to by number only, except when specific reference is necessary to meet the goals of the CQMP. All written records, reports or other work products, and communications related to CQM activities are considered privileged and confidential information.

### **UnitedHealthcare's Population Health and System Support Department**

Population Health and System Support offers multiple educational programs for eligible beneficiaries. Education is provided through the mail, telephone, or Internet.

### **Healthcare Effectiveness Data and Information Set Measurements**

UnitedHealthcare uses the Healthcare Effectiveness Data and Information Set (HEDIS®) effectiveness-of-care measures. This tool, developed by the National Committee for Quality Assurance (NCQA), is used by more than 90% of America's health plans to measure performance regarding important dimensions of care and service.

Many health plans report HEDIS data to employers or use data results to improve quality of care and service. UnitedHealthcare monitors effectiveness of care specific to the TRICARE Prime population assigned to network PCMs for a broad range of important health issues, including:

- Breast cancer screening:
  - › Measure: percentage of women ages 42–64 who had at least 1 mammogram in the past 2 years
- Cervical cancer screening:
  - › Measure: percentage of women ages 21–64, without a documented hysterectomy, who were continuously enrolled during the proceeding 36-month period
- Colorectal cancer screening:
  - › Measure: percentage of men and women ages 51–64 who were continuously enrolled during the proceeding 24-month period (Patients with a diagnosis of colorectal cancer or with a previous total colostomy are excluded.)

HEDIS 2011 measurements also include:

- Comprehensive diabetes care:
  - › Measures: percentage of beneficiaries ages 18–64 with diabetes (type 1 and type 2) who had each of the following:
    - Hemoglobin A1c (HbA1c) testing
    - Poorly controlled HbA1c levels (greater than 9.0)
    - Good HbA1c control (level less than 7.0)

- Eye examination (retinal) performed
- Serum cholesterol level (LDL-C) screening
- Cholesterol level (LDL-C) controlled to less than 100 mg/dl
- Medical attention for kidney disease (nephropathy)
- Blood pressure control (less than 130/80 mm Hg)
- Blood pressure control (less than 140/90 mm Hg)
- Use of appropriate medications for people with asthma
  - › Measure: percentage of enrolled beneficiaries ages 5–64 with persistent asthma who were prescribed medications acceptable as primary therapy for long-term asthma control

For further information on HEDIS measures, visit the NCQA website at [NCQA.org](http://NCQA.org).

## **Condition (Disease) Management**

UnitedHealthcare offers a beneficiary-focused Condition Management Program designed to help TRICARE West Region beneficiaries with specific conditions take a more active role in their own health care.

UnitedHealthcare’s Condition Management Program is a prospective, disease-specific approach to improving health care outcomes by providing one-on-one education to beneficiaries with a health coach registered nurse (RN), licensed respiratory therapist (RT), licensed clinical social worker (LCSW), or pharmacist. The Condition Management Program also offers nutrition counseling with registered dietitians as well as exercise counseling with exercise specialists. The program’s goal is to provide beneficiaries with skills to manage their health conditions. A telephonic tobacco-cessation class is offered weekly to support beneficiaries in quitting tobacco use. Telephonic carbohydrate counting/exercise for life classes, as well as a diabetes support group, are offered monthly. An advanced carbohydrate counting class is offered quarterly. Health coach clinicians (RNs, RTs, and LCSWs) work one-on-one with beneficiaries, providing support, educational materials, and strategies to handle health challenges, as well as skills to improve their quality of life.

TRICARE-eligible beneficiaries with 1 or more of the following 6 conditions may benefit from participating in UnitedHealthcare’s Condition Management Program:

- Anxiety disorder
- Asthma (adults and children)
- Heart failure
- Diabetes (adults and children)
- Chronic obstructive pulmonary disease
- Major depression

Additional programs may be added periodically.

Beneficiaries are identified by the DoD on a bimonthly basis as candidates for a Condition Management Program. Only these beneficiaries are eligible for a Condition Management Program. The minimum criteria for program enrollment are 1 or more emergency room visits or 1 or more inpatient admissions with the listed primary diagnoses. UnitedHealthcare’s intensive portion of the program averages 6 to 9 months in duration, depending on the amount of support and education the beneficiary requires. Once the beneficiary completes the intensive program, he or she will receive follow-up calls at 6 and 12 months. The purpose of the calls is to assess further education needs and to review beneficiary progress and adherence to the program.

For more information about the Condition Management Program, please contact the Condition Management Department at (877) 988-WEST/(877) 988-9378 or visit [uhcmilitarywest](#) → Clinical Information for health and wellness information.

## **Health and Wellness**

To encourage beneficiaries to maintain or adopt healthy lifestyle habits, UnitedHealthcare offers health and wellness information at [uhcmilitarywest.com](#) on the “Healthy Living” Web page. The information provided is available to all beneficiaries. There are also links to many DoD health improvement sites.

## **Case Management**

Case management takes a collaborative, integrated approach to managing the complex health care needs of an eligible beneficiary. Case-management programs include medical/surgical and behavioral health case management, as well as specialty programs, such as cancer clinical trials, the TRICARE ECHO program, and transplants.

Case management is a process designed to assess, plan, implement, coordinate, monitor, and evaluate the options and services necessary to meet an individual’s health care needs. Using communication and available resources to promote quality, cost-effective outcomes, case managers work one-on-one with the providers. UnitedHealthcare case managers act as beneficiary advocates, working with multidisciplinary teams using clinical skills and knowledge to assure that the best possible care is provided.

Beneficiaries who have complex, catastrophic health care needs may benefit from the case management program. The beneficiary, a family member, or a provider can make referrals to case management by contacting UnitedHealthcare. An MTF or a member of UnitedHealthcare’s staff may also refer beneficiaries to case management. When a beneficiary is in case management, his or her case manager may provide multiple services, including:

- Identifying and facilitating needed services and equipment, and promoting the beneficiary’s self care in collaboration with the PCM for optimal health care delivery and in conjunction with MTF and VA resources
- Decreasing the provider’s administrative tasks by assisting with referrals and authorizations and locating specialty providers
- Educating the beneficiary on TRICARE benefits and systems
- Identifying community resources
- Educating the beneficiary on his or her disease process and promoting lifestyle changes that can positively affect the management of the disease (e.g., compliance with the recommended treatment plan, adherence to medication regimen, keeping scheduled physician appointments)
- Providing a point of contact to assist with problem solving, acting as a beneficiary advocate, and assisting in communicating with caregivers on behalf of the beneficiary

The following may be appropriate for case management:

- Acute HIV/AIDS
- Admissions to a neonatal intensive care unit
- All residential treatment center admissions
- Behavioral health care admissions of children age 12 and younger
- Bone marrow procedures
- Burns (third degree or extensive second degree)



- Cardiovascular conditions
- ECHO registration
- Expected multiple births
- Head trauma
- History of intensive care for an infant
- Life-threatening suicide attempt
- Neoplasms and malignancy
- Neurological conditions involving intensive care or unconsciousness for more than 48 hours
- Obstetrical conditions that require hospitalization prior to delivery
- Participation in National Cancer Institute Phase I, II, or III cancer clinical trials
- Psychiatric residential treatment center admissions for adolescents
- Respiratory failure with new ventilator dependence post hospitalization
- Severely injured ADSMs
- Spinal cord injuries
- Transplants (organ, bone marrow, or stem cell)
- 2 inpatient behavioral health care admissions within 90 days

To refer a TRICARE beneficiary to the program, download a *Case Management Patient Referral Form* available on [uhcmilitarywest.com](http://uhcmilitarywest.com) → Beneficiary → Find A Form → Clinical Programs.

## **Fraud and Abuse**

Program integrity is a comprehensive approach to detecting and preventing fraud and abuse. Prevention and detection are a result of functions of the prepayment control system, the post-payment evaluation system, quality-assurance activities, reports from beneficiaries, and identification by a provider's employees or UnitedHealthcare staff.

TMA has a specific office to oversee the fraud and abuse program for TRICARE. The TRICARE Management Activity (TMA) Program Integrity (PI) Office is responsible for all anti-fraud activities worldwide for the Defense Health Program.

Some examples of fraud include:

- Agreements or arrangements between the provider and the beneficiary that result in billings or claims for unnecessary costs or charges to TRICARE
- Billing for costs of non-covered or non-chargeable services, supplies, or equipment disguised as covered items
- Billing for services, supplies, or equipment not furnished or used by the beneficiary
- Duplicate billings (e.g., billing more than once for the same service, billing TRICARE and the beneficiary for the same services, submitting claims to both TRICARE and other third parties without making full disclosure of relevant facts or immediate full refunds in the case of overpayment by TRICARE)
- Misrepresentations of dates, frequency, duration, or description of services rendered, or the identity of the recipient of the service or who provided the service
- Practicing with an expired, revoked, or restricted license, because an expired or revoked license in any of the United States or its territories will result in a loss of authorized provider status under TRICARE

- Reciprocal billing (i.e., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed)
- Violation of the participation agreement that results in the beneficiary being billed for amounts that exceed the TRICARE-allowable charge or negotiated rate

The TRICARE Program Integrity office also reviews potential abuse referrals (practices inconsistent with sound fiscal, business, or medical procedures and services not considered to be reasonable and necessary) and cases of potential abuse. Such referrals and cases of abuse often result in inappropriate claims for TRICARE payment.

Some examples of abuse include:

- Care of inferior quality (does not meet accepted standards of care)
- Charging TRICARE beneficiaries rates for services and supplies that are in excess of those charged to the general public, such as by commercial insurance carriers or other federal health benefit entitlement programs
- Failure to maintain adequate clinical or financial records
- A pattern of claims for services that are not medically necessary, or, if necessary, not to the extent rendered
- A pattern of waiver of beneficiary (patient) copayment, cost-share, or deductible
- Refusal to furnish or allow access to records
- Unauthorized use of the term “TRICARE®” in private business, including in advertisements and website postings directed to TRICARE beneficiaries

Providers are cautioned that unbundling, fragmenting, or code gaming to manipulate CPT codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such practice can be considered fraudulent and abusive.

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 TMA Office of General Counsel is responsible for providing legal counsel and legal services to the TMA Program Integrity Office. The DoD Office of Inspector General and other agencies investigate TRICARE fraud.

To anonymously report suspected fraud and/or abuse:

- Call the UnitedHealthcare Fraud Hotline at (888) 899-5071.
- Go online at [www.dodig.mil/hotline/](http://www.dodig.mil/hotline/)

Please provide as much information as possible, including:

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

For additional information, please refer to [tricare.mil/fraud/](http://tricare.mil/fraud/) 32 CFR 199.9.

## **Grievances**

If a provider or beneficiary has concerns about a level or quality of services or care received through the TRICARE program, the provider or beneficiary has a right to file a grievance with UnitedHealthcare.

A grievance is a written complaint on a non-appealable issue regarding a perceived failure by any member of the health care delivery team. Grievances may include such issues as:

- Appropriateness of care

- Availability of services
- Inappropriate behavior on the part of a health care provider or the provider's staff
- The performance of any part of the health care delivery system
- Practices related to patient safety
- Quality of care
- Timeliness of services

Grievances received by UnitedHealthcare are reviewed to determine the proper course of action. To follow the formal grievance procedure, grievances must be submitted in writing and include any supporting documentation that may assist in reviewing the grievance. Grievances should be mailed to:

UnitedHealthcare Military & Veterans  
 Appeals and Grievances  
 P.O. Box 105493  
 Atlanta, GA 30348

Grievances may also be submitted by fax to Appeals & Grievances at (877) 584-6628 to the attention of the Customer Relations department. This fax machine is located in a secure location within the Customer Relations department, and confidentiality is assured. UnitedHealthcare reviews the grievance and provides a response within 30 calendar days from the date of receipt. If the grievance investigation and response cannot be completed within the allotted 30 days, an interim notice is mailed, with a final response to be completed within 60 calendar days. If the individual who filed the grievance is dissatisfied with the outcome, he or she may request an appeal of the review decision in writing.

## **Appeals**

TRICARE beneficiaries and non-network participating providers have the right to appeal decisions made by UnitedHealthcare.

The appeals process varies, depending on whether the denial of benefits involves medical necessity determination, factual determination, or a provider sanction. All initial and appealed denials explain how, where, and by when to file the next level of appeal. An appeal cannot challenge the propriety, equity, or legality of any provision of law or regulation.

### **Proper Appealing Parties**

- The TRICARE beneficiary (including minors)
- The non-network participating provider (accepts assignment) of services
- A non-network participating provider (accepts assignment) appealing a preadmission/preprocedure denial (when services have not been rendered)
- A provider who has been denied approval as a TRICARE-authorized provider or who has been terminated, excluded, suspended, or otherwise sanctioned
- A person who has been appointed in writing by the beneficiary to represent him or her in the appeal
- An attorney filing on behalf of a beneficiary
- A custodial parent or guardian of a beneficiary under age 18

To avoid possible conflict of interest, an officer or employee of the U.S. Government, such as an employee or member of the uniformed services (including an employee or staff member of a uniformed services legal office), or a Beneficiary Counseling and Assistance Coordinator, subject to exceptions in Title 18, United States Code, Section 205, is not eligible to serve as a representative unless the beneficiary is an immediate family member.

## Medical Necessity Determinations

Medical necessity determinations are based solely on whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the beneficiary's condition. Generally, determinations relating to behavioral health benefits are considered medical necessity determinations. The appeal process for non-expedited medical-necessity determinations is listed below. There are expedited procedures for appealing decisions denying requests for prior authorization of services and requests for continued inpatient stays. If an expedited appeal is available, the initial and appealed denial decisions will fully explain how to file an expedited appeal.

- **Expedited appeal:** shall be received by UnitedHealthcare within 3 calendar days of the date of the receipt of the initial denial determination notification. Only the beneficiary, or the beneficiary's representative, may request an expedited appeal.
- **Non-expedited appeal:** shall be received by UnitedHealthcare within 90 days of the date of initial denial determination notification.

## Factual Determinations

Factual determinations involve issues other than medical necessity. Some examples of factual determinations include: coverage issues (i.e., determining whether the service is covered under TRICARE policy or regulation), foreign claims, and denial of a provider's request for approval as a TRICARE-authorized provider. Factual determinations must be received by UnitedHealthcare within 90 calendar days of the date of the initial denial determination notification.

## Provider Sanction Determinations

Providers who request approval as TRICARE-authorized providers, but are denied approval by either TMA or UnitedHealthcare, may appeal those decisions and request a reconsideration determination. Provider-sanction determinations occur when providers are expelled from TRICARE. Providers may be sanctioned by TRICARE because of failure to maintain credentials, provider fraud, abuse, conflict of interest, or other reasons. Only the provider or his or her representative can appeal. If the sanctions are appealed, an independent hearing officer will conduct a hearing administered by the TMA Appeals and Hearings Division. Providers who are not eligible for authorization by TRICARE because of fraud and abuse against another federal or federally funded program or a state or local licensing authority (e.g., Medicare or Medicaid) may not appeal through the TRICARE system.

## Appeal Filing Deadlines

An appeal must be filed before the expiration of the appeal filing deadline or within 20 calendar days of the date of the contractor's letter of notification of an improper appealing party filing. The letter of notification includes information for providers to submit these appeals. There must be a denial of an appeal due to untimely filing before an extension can be considered.

## Levels of Appeals

- Level 1. Request for reconsideration of the initial denial by UnitedHealthcare
- Level 2. If the reconsideration results in the denial being upheld, then:
  - › Medical necessity—appeal to the TQMC, KePRO
  - › Factual—appeal to TMA

## Non-Appealable Issues

- POS determinations, with the exception of whether services were related to an emergency and are, therefore, exempt from the requirement for referral and authorization
- Allowable charges (the TRICARE-allowable charge for services or supplies is established by regulation)

- A beneficiary's eligibility, because this determination is the responsibility of the uniformed services
- Provider sanction (the provider is limited to exhausting administrative appeal rights)
- Network provider/contractor disputes
- Denial of services from an unauthorized provider
- Denial of a treatment plan when an alternative treatment plan is selected
- Denial of services by a PCM
- Denial of nonavailability statement (NAS) issuance
- Denial of registration into the ECHO program (if all eligibility criteria are not met)

### **Post-Service Prepayment Review (PSPR)**

A PSPR is used to appeal a denial of payment for health care services that required an approval prior to being rendered. PSPR requests only apply to medical necessity issues after services have been rendered.

PSPR requests must be submitted in writing – either by the beneficiary or the non-network participating provider – to PGBA in order to receive TRICARE reimbursement. A PSPR does not apply to factual benefit determinations (e.g., if TRICARE does not cover the service). A PSPR may be considered when neither the non-network participating provider nor the beneficiary could have reasonably known the service would be denied based on medical necessity or appropriateness.

A TRICARE beneficiary is not held liable for charges if the provider had prior knowledge that the services were excluded. Additionally, subject to application of other TRICARE definitions and criteria, the principle of waiver of liability is summarized as follows:

If the beneficiary did not know, or could not reasonably be expected to know, that certain services were potentially excludable from the basic TRICARE program by virtue of

1. Not being medically necessary
2. Not provided at an appropriate level
3. Or other reason relative to reasonableness, necessity, or appropriateness

then the beneficiary will not be held liable for such services. Under certain circumstances, payment may be made for the excludable services as if the exclusion for such services did not apply. A PSPR does not apply if the non-network participating provider or beneficiary had prior knowledge that the services were excludable.

A PSPR also does not apply to services provided by a network provider. Network providers may never bill beneficiaries for services denied for medical necessity or appropriateness. This requirement does not apply to TRICARE network pharmacies.

If a PSPR request is denied, then the TRICARE beneficiary can be held financially liable if 1 of the following situations applies:

- Both the non-network participating provider and the beneficiary knew the services were excluded
- The beneficiary did not notify the non-network participating provider about having TRICARE coverage
- The beneficiary knew the services were excluded but the non-network participating provider did not

Supporting documentation and the PSPR request and related information may be submitted to:

TRICARE West Region  
Correspondence Department  
P.O. Box 7065  
Camden, SC 29020 -7065

# Claims Processing and Billing Information

## West Region Claims Processor

PGBA is UnitedHealthcare's contractor for claims processing in the TRICARE West Region. For claims processing information, visit [uhcmilitarywest.com](http://uhcmilitarywest.com).

To contact PGBA about claims for beneficiaries eligible for both Medicare and TRICARE, see the explanation about filing claims for these beneficiaries later in this section.

Note: UnitedHealthcare does **not** administer the contract for TFL. You will need to contact the division of PGBA that administers this contract for TFL claims information. For more information, see [Claims for Beneficiaries Using Medicare and TRICARE](#) later in this section.

You may check the status of non-TFL claims by registering for the secure area of [uhcmilitarywest.com](http://uhcmilitarywest.com).

## Claims Forms

### CMS-1500

The *CMS-1500* form is used by physicians and other providers to bill government and commercial health plans.

Please contact the PGBA Electronic Data Interchange (EDI) Help Desk at (800) 325-5920 to obtain additional information on submitting claims electronically. Providers are strongly encouraged to file claims electronically.

### UB-04

The *UB-04* form (or the 837 Institutional Transaction Set) is used by hospitals and other institutional providers to bill government and commercial health plans.

Note: The signature of non-network providers, or an acceptable facsimile, is required on all non-network claims in accordance with the *TRICARE Operations Manual*, Chapter 8, Section 4 at <http://manuals.tricare.osd.mil>. **If a non-network claim does not contain an acceptable signature, the claim will be returned.** Because the provider's signature block Form Locator (FL) was eliminated from the *UB-04*, the National Uniform Billing Committee has designated FL 80 (Remarks), as the location for the non-network provider signature if signature-on-file requirements do not apply to the claim.

## Claims Processing Standards and Guidelines

### Filing Claims: Electronic Data Interchange (EDI)

PGBA staff members are skilled in working with a variety of provider specialties, billing services, and software vendors. Choosing 1 of their EDI options assures you assistance throughout the claims-filing process. The EDI edit systems are designed to minimize data entry errors before claims are passed to the PGBA processing system. Providers are strongly encouraged to file electronically.

#### **EDI Software Option**

You may choose an EDI software program from a vendor, clearinghouse, or billing service whose software already has been approved for TRICARE electronic claims submission. PGBA's website, [www.myTRICARE.com](http://www.myTRICARE.com) provides all of the information you need to make an informed vendor or clearinghouse selection.

#### **EDI Companion Guides**

Two EDI companion guides are available by clicking the "EDI/ERA/EFT" link at [uhcmilitarywest.com](http://uhcmilitarywest.com):

- 835 Electronic Remittance Advice Transaction
- 837 Claims Submission



HIPAA requires all health insurance payers in the United States to comply with the EDI standards for health care as established by the secretary of the U.S. Department of Health and Human Services. The ANSI X12N 837 implementation guides have been established as the standard for compliance for claims transactions.

UnitedHealthcare's guides serve only as companion documents to the HIPAA ANSI X12N 837 Professional, Institutional, and Dental implementation guides. The information describes specific requirements to be used for processing data in the TRICARE processing system of PGBA.

When submitting claims, use the proper number of units for each line. For example, 1 visit is 1 unit. Behavioral health care providers must code each service on a separate line.

### ***PGBA Electronic Data Interchange Contact Information***

For information about filing claims electronically, you may contact PGBA by phone, email, or at their website:

<b>Phone</b>	(800) 325-5920, Option 2
<b>Email</b>	edi.tricare@pgba.com
<b>website</b>	www.mytricare.com

### **Filing Paper Claims**

If you are unable to submit claims electronically, please call (877) 988-9378.

### **Electronic Funds Transfer (EFT)**

UnitedHealthcare offers EFT to network West Region providers. To be eligible for EFT, network providers must accept Electronic Remittance Advise (ERAs) and agree to discontinue paper remittance advices.

To enroll for EFT, download the *Electronic Funds Transfer* form at [UhcMilitaryWest.com](http://UhcMilitaryWest.com) → Find a Form → General.

### **Claims Processing Timelines**

UnitedHealthcare and PGBA are committed to processing 98% of all clean claims (i.e., claims received with all necessary information and documentation) in 30 days. TRICARE claims-filing guidelines are similar to, but not necessarily the same as, Medicare's. You should not submit referrals, authorizations, or medical records with the claim. UnitedHealthcare's referral and authorization system will link the claims to referrals and authorizations that have been entered by providers on UnitedHealthcare's secure website or by UnitedHealthcare staff. See the [Health Care Management and Administration](#) section for guidelines for referrals and authorizations.

Allow at least 30 days to receive payment or a provider remittance advice before resubmitting claims, as PGBA has 30 days from the date of receipt to process the claim. If you have registered for the secure area of [uhcmilitarywest.com](http://uhcmilitarywest.com), you may check claims status online. Registered users have several search options to easily find claims associated with their office(s). The search criteria includes:

- Search by process date
- Search by claim number
- Search by patient account number
- Search by check number
- Search by individual provider

UnitedHealthcare will also respond to HIPAA-compliant Transaction 276/277.

### **Tracer Claims**

Please avoid submitting tracer (second submission) claims. Use the secure area of [uhcmilitarywest.com](http://uhcmilitarywest.com) to verify claims status or call (877) 988-9378 (Claims Option for Claim Status). All claims submitted are acknowledged

either with a payment, a provider remittance advice, or, in rare instances, returned with a specific request for additional information. In no case is a claim received and not acknowledged.

You may check claims status in the secure area of [uhcmilitarywest.com](http://uhcmilitarywest.com) regardless of how the claim was submitted. Please refer to “Claims Processing Timelines” earlier in this section for additional information.

### Interest Charges

You cannot bill penalties or interest charges to a beneficiary if TRICARE fails to make timely payment on a bill. TRICARE pays interest on claims that are processed more than 30 days after receipt.

### HIPAA National Provider Identifier Compliance

All covered entities must use their NPIs on HIPAA standard electronic transactions in accordance with the appropriate HIPAA Implementation Guide. When filing claims with NPIs, billing NPIs are always required and rendering provider NPIs, when applicable, are also required.

Providers treating TRICARE beneficiaries as a result of referrals should also obtain the referring provider’s NPI and include it on transactions, if available, per the Implementation Guide for each transaction. See the *Important Provider Information* section of this Handbook for additional details on HIPAA NPI compliance.

### Unlisted Codes and Required Information

Some procedures may not be found in any level of the Healthcare Common Procedure Coding System (HCPCS). Typically, these are services that are rarely provided, or are unusual, variable, or unlisted procedures. In order for UnitedHealthcare to make an appropriate benefit determination, prior authorization for all unlisted codes is required.

In accordance with TRICARE requirements as well as industry standards, UnitedHealthcare requires additional information if unlisted codes, or not otherwise categorized (NOC) codes, are billed on a claim.

Figure 8.1 includes examples of Current Procedural Terminology (CPT®) codes, text description required, and documentation required. If a text note or documentation is required, UnitedHealthcare prefers that the text is entered on the documentation with a paper claim.

Note: Prior authorization is required for all unlisted codes.

**Unlisted Codes and Required Information**

**Figure 8.1**

Category of Unlisted Procedures	CPT Code Examples	Required Text, Documentation, Both, or Either	Text Description Required	Documentation Required
<b>Anesthesia</b>	01999	Documentation		Surgeon's operative report
<b>Surgery</b>	15999, 17999	Documentation		Surgeon's operative report
<b>Procedure</b>	36299, 38999	Either	Detailed description of the approved procedure	Procedure report
<b>Radiology</b>	76498, 76499	Either	Detailed description of the approved radiology procedure	Radiology report
<b>Radiation Therapy</b>	77799, 78299	Documentation		Report signed by the physician indicating what services were performed
<b>Laboratory</b>	87899, 88199	Documentation		Laboratory report
<b>Pathology</b>	88399, 89240	Documentation		Pathology report pointing out the specific test used

Category of Unlisted Procedures	CPT Code Examples	Required Text, Documentation, Both, or Either	Text Description Required	Documentation Required
<b>Drugs</b>	J3490, J7199, C9399	Text	Drug name, unit of measure (mg, ml, or units), drug quantity, and National Drug Code if applicable	
<b>Evaluation and Management</b>	99429, 99499	Text	Detailed description of the approved office service performed	
<b>Home Services</b>	99600	Text	Detailed description of the approved services	
<b>Supplies/ Durable Medical Equipment</b>	L8699, E1399	Documentation		Supplier's invoice
<b>Enterals/ Parenterals</b>	B9998, B9999	Documentation		Supplier's invoice
<b>Ambulance</b>	A0999	Text	Detailed description of services	

For more information, refer to the *Claims/Payment* section of [uhcmilitarywest.com](http://uhcmilitarywest.com).

### Timely Filing

Network providers, by virtue of their contracts with UnitedHealthcare, should file all claims within 30 days. TRICARE requires that all claims be submitted to UnitedHealthcare no later than 1 year after the date the services were provided or 1 year from the date of discharge for an inpatient admission for facility charges billed by the facility. Professional services billed by the facility must be submitted within 1 year from the date of service or 1 year from the date of discharge for an inpatient admission.

A request for an exception to the claims filing deadline may be submitted by participating providers who are registered users of [uhcmilitarywest.com](http://uhcmilitarywest.com) for consideration on a case-by-case basis. Appropriate attachments, a letter and copy of the claim may be submitted to:

TRICARE West Region  
Correspondence Department  
P.O. Box 7065  
Camden, SC 29020 -7065

UnitedHealthcare reviews and gives individual consideration to each case.

After the proper claim has been submitted and an exception to the claims filing deadline granted, UnitedHealthcare considers only those services or supplies received during the 6-year period immediately preceding the receipt of the request.

### Returning Incorrect Payments

If you receive an overpayment for a claim for TRICARE Prime, TPR, TPRADFM, TRICARE Standard and TRICARE Extra, TRS, TRR, or TYA beneficiaries, return it to PGBA. Overpayments for TFL claims also must be returned to PGBA, but to a different address, as noted below.

To accurately credit the refund to the correct claim when returning payments, include a copy of the provider remittance advice or ERA. If one of these documents is not available, include the TRICARE claim number, the last 4 digits of the sponsor's SSN or DBN, beneficiary's name, refund calculation, and any other pertinent information.

Return duplicate payments or overpayments (except TFL) to:

TRICARE West Region Refunds  
P.O. Box 100268  
Columbia, SC 29202

Return TFL duplicate payments or overpayments to:

Wisconsin Physicians Service  
ATTN: Refunds  
P.O. Box 7928  
Madison, WI 53707-7928

### **West Region Recoupments**

When UnitedHealthcare, PGBA, or TMA identifies an overpayment, recoupment is set up in accordance with the *TRICARE Operations Manual*, Chapter 10, Section 3 and 4 at <http://manuals.tricare.osd.mil>.

An initial letter and a 30-day follow-up letter are mailed to the billing address of the group or facility. If the overpayment is returned by the provider in accordance with “Returning Incorrect Payments” earlier in this section, the recoupment case is closed. To accurately credit the recoupment to the correct case, include a copy of the original recoupment letter with the remittance.

If there is an overpayment balance remaining, UnitedHealthcare will offset it against current claims. The claims system will search for unpaid claims under the provider’s 18-digit group or facility number. If there are claims to be paid, those claims will be offset against the recoupment. If there are no unpaid claims under the 18-digit number, and there are unpaid claims under the provider’s Tax Identification Number (TIN), the offset is made against claims at the TIN level.

### **Modifiers**

Industry-standard modifiers are often 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 physician to indicate 1 of the following:

- A service or procedure has both a professional and technical component
- A service or procedure was performed by more than 1 physician and/or in more than one location
- A service or procedure has been increased or reduced
- Only part of a service, an adjunctive service, or a bilateral service was performed
- A service or procedure was provided more than once
- Unusual events occurred during the service
- A procedure was terminated prior to completion

### **Signature-on-File Requirements**

When a TRICARE beneficiary has signed a *Release of Information* statement, you should indicate “signature on file” in Box 12 of the *CMS-1500*. A new signature is required every year for professional claims submitted on a *CMS-1500* and for every admission for claims submitted on a *UB-04*.

If the beneficiary is under age 18, the parent or legal guardian should sign the claim. However, a beneficiary under age 18 may sign the claim form if the beneficiary is (or was) the spouse of an ADSM or retiree, or if the services are related to venereal disease, drug or alcohol abuse, or abortion.

In situations when a beneficiary is mentally incompetent or physically incapable, the person signing should either be the legal guardian or, in the absence of a legal guardian, a spouse or parent of the beneficiary. See the *Important Provider Information* section of this Handbook for more information about the release of patient information.

If the beneficiary is deceased, and you do not have a valid signature-on-file agreement, you must submit 1 of the following:

- A claim form signed by the legal representative of the estate.
- Documentation accompanying the claim form to show the person signing is the legally appointed representative.
- If no legal representative has been appointed, the parent, spouse, or next of kin may sign the claim form. The signer must provide a statement that no legal representative has been appointed. The statement should contain the date of the beneficiary's death and the signer's relationship to the beneficiary.
- In the event there is no spouse, parent, or guardian to sign the claim form, the claim must be signed by the surviving next of kin or a legally appointed representative (indicate relationship to beneficiary).
- When there is no spouse, parent, guardian, next of kin, or legal representative to sign the claim form for a deceased beneficiary, payment may be made to the provider in accordance with state law and UnitedHealthcare corporate policy.

Signatures from the following individuals are not acceptable as beneficiary signatures:

- A provider or an employee of an institution rendering care
- An employee of an entity submitting a claim on behalf of a beneficiary, unless such employee is the beneficiary's parent, legal guardian, or spouse

Claims submitted for diagnostic tests, test interpretations, or other similar services do not require the beneficiary's signature. When submitting these claims, you must indicate "patient not present" on the claim form.

TRICARE randomly reviews claims to confirm that signature-on-file requirements are being followed.

## **Physician Attestation Requirements**

It is not necessary to submit a signed physician attestation form with each claim submitted for payment. However, any TRICARE institution submitting claims for an attending physician must have a signed and dated acknowledgement from the attending physician on file indicating that the physician has received the following notice:

"Notice to Physicians: TRICARE payment to hospitals is based in part on each beneficiary's principal and secondary diagnoses and the major procedures performed on the beneficiary, as attested to by the beneficiary's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fines, imprisonment, or civil penalty under applicable federal laws."

The physician should sign this acknowledgement at the time he or she is granted admitting privileges. The signed and dated acknowledgement remains in effect as long as the physician has admitting privileges at the institution.

Note: The facility may use the Medicare physician attestation form and modify it to cover both Medicare and TRICARE. Any existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital. The attestations may be audited/reviewed and the absence of an attestation may result in nonpayment/recoupment.

## Special Processing Instructions

### Lab and Radiology Billing

When submitting claims for laboratory or radiology services rendered in a hospital setting, inpatient or outpatient, and you are a professional provider, use modifier 26 to indicate that you are billing for the professional component only. The hospital will submit claims for the technical component.

When submitting claims for laboratory or radiology services rendered in an office setting and you are a professional provider, indicate whether or not you are billing for the global fee or only the professional component. Use modifier 26 to indicate you are billing for the professional component only if sending the sample to a laboratory. You should also check “yes” in Box 20 of the *CMS-1500* or 837 transaction. This allows payment to the laboratory for the technical component. If you do not use a modifier and do not indicate “yes” in Box 20 of the *CMS-1500*, you will be paid the global fee. Should the laboratory subsequently bill for the technical component, that claim will be denied.

Note: Clinical labs billing for services for inpatient hospital patients must bill the facility, not TRICARE, for the lab tests. Repeated failure to follow this rule will cause the clinical lab to have all claims returned to them without processing.

### Venipuncture

Venipuncture is denied or paid based on the setting in which it is provided. Denial or payment is also determined by whether or not the lab results are read by the provider of care. When submitting venipuncture claims, specify “yes” or “no” in Box 20 of the *CMS-1500* or 837 transaction to indicate if an outside laboratory was used. If the labs are drawn in a provider’s office, but read in an outside laboratory, TRICARE pays for the venipuncture.

### Allergy Testing and Treatment Claims

Certain types of allergy tests are not covered under TRICARE. Prior to completing an allergy test, determine if the service is a covered benefit, if it requires a referral or an authorization, or if the service needs medical review.

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 up-to-date CPT-4 code book definitions of relevant codes. In Column 24G (Days or Units) of the *CMS-1500* claim form, indicate the number of replacement antigen sets (not vials) being billed.

A limited number of replacement antigen sets are payable pending medical review and approval. Always bill with the appropriate CPT code, whether the replacement set consists of 1 vial or 2 or more vials.

### Global Maternity Claims

Global maternity involves the billing process for maternity-related claims for a beneficiary. Once a beneficiary has been diagnosed as pregnant, all charges related to the pregnancy are grouped under 1 global maternity diagnosis code.

These diagnosis codes will be listed as the primary diagnosis when billing. Figure 8.2 lists examples of these codes.

When beneficiaries are referred for specialty obstetric care, prior authorization must be obtained for both outpatient and inpatient services.

Maternal Serum Alpha Fetoprotein and Multiple Marker Screen Test are cost-shared separately (outside 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 1 to 2 weeks after discharge from the hospital as recommended by the American Academy of Pediatrics®.



Professional and technical components of medically necessary fetal ultrasounds are covered outside 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 the condition of the fetus in late registrants for prenatal care.

**Global Maternity Diagnosis Code Examples**

**Figure 8.2**

ICD-9 Code (before 10/1/2014)	ICD-10 Code (on or after 10/1/2014)	Description
V22	Z34	Normal pregnancy
V22.0	Z34.01	Supervision of normal first pregnancy
V22.1	Z34.81	Supervision of other normal pregnancy
V22.2	Z33.1	Pregnant state, incidental

## ClaimCheck

The TRICARE West Region contract uses a version of the McKesson HBOC ClaimCheck® product to review non-Outpatient Prospective Payment System (non-OPPS) claims on a prepayment basis for unbundling. ClaimCheck is an automated product that contains specific auditing logic designed to evaluate professional billing for CPT coding appropriateness and to eliminate overpayment.

The current Web-based version (ClaimCheck 8.5.47) has the ability to read up to 4 modifiers on each claim line, as well as the ability to handle HCPCS codes the same way as CPT codes.

## ClaimCheck Edits

You should follow CPT coding guidelines to prevent claim denials due to ClaimCheck editing. Any edits made by ClaimCheck will be explained by a message code on the provider remittance advice. ClaimCheck includes the following edit categories:

- Age Conflicts
- Alternate Code Replacements
- Assistant Surgeon Requirements
- Billed Date(s) of Service
- Cosmetic Procedures
- Duplicate and Bilateral Procedures
- Gender Conflicts
- Incidental Procedure
- Modifier Auditing
- Mutually Exclusive Procedure
- Preoperative (pre-op) and Postoperative (post-op) Auditing Billed
- Procedure Unbundling
- Unlisted Procedures

The complete set of code edits is proprietary and, as such, cannot be released to the general public.

## **Electrocardiograms and Office Visit Billing**

When an electrocardiogram (ECG) is done in conjunction with an evaluation and management (E&M) visit and is billed separately, TRICARE does not pay this service separately since an E&M visit is determined by time and the ECG review is a part of that time. A “Procedure Unbundling” edit will appear on the provider remittance advice. If additional time was taken to perform the ECG, a higher-level code should be used for the office visit.

## **Claims for Mutually Exclusive Procedures**

Mutually exclusive procedures are 2 or more procedures that are usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedure, where the physician should be submitting only 1 procedure code. Example: Procedure 58260 (vaginal hysterectomy) and procedure 58150 (total abdominal hysterectomy) are considered to be mutually exclusive.

## **ClaimCheck Review Requests**

ClaimCheck findings are “allowable charge determinations” and, as such, are not appealable. However, participating providers do have recourse through medical review. Issues appropriate for medical review include:

- Requests for verification that the edit was correctly applied to the claim
- Requests for an explanation of ClaimCheck auditing logic
- Situations in which you submit additional documentation substantiating that unusual circumstances existed

Requests for review of ClaimCheck edits must be received within 90 days of the date of the remittance advice and are resolved within 45 days of receipt. Participating providers who are interested in a medical review should request consideration on a case-by-case basis. Appropriate attachments with supporting documentation, a letter and copy of the claim may be submitted to:

TRICARE West Region  
Correspondence Department  
P.O. Box 7065  
Camden, SC 29020-7065

Following medical review, UnitedHealthcare may override the ClaimCheck edit and allow additional amounts to be paid.

You are not permitted to bill TRICARE beneficiaries for amounts considered unbundled or incidental by ClaimCheck.

## **TRICARE Claim Disputes**

In the event you disagree with reimbursement rates, you may request a claim review (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 promptly resolve your request.

## **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:

- Allowable charge disputes
- Charges denied as “included in a paid service”
- Wrong code
- Eligibility denials
- Cost-share and deductible inquiries/disputes
- Claims denied as “provider not authorized”
- Claims denied as not medically necessary
- OHI denials/issues
- Third-party liability denials/issues
- Penalties for a non-authorized service
- Claims processed as Point-of-Service
- Claims denied as “requested information was not received”
- Coding issues

If requesting an allowable charge review, you must submit the following information:

- Letter with the reason for requesting the claim review
- A copy of the claim and the TRICARE EOB or TRICARE summary payment voucher/remit
- Supporting medical records and any new information that was not originally submitted with the claim

**Note:** Requests must be postmarked or received within 90 calendar days of the date of the TRICARE summary payment voucher or EOB.

Your request and appropriate attachments should be mailed to:

TRICARE West Region  
Correspondence Department  
P.O. Box 7065  
Camden, SC 29020 -7065

For information about filing an appeal, see the [Health Care Management and Administration](#) section of this Handbook.

## **Outpatient Institutional Claims Processing**

UnitedHealthcare uses the Centers for Medicare and Medicaid Services (CMS) guidelines for reimbursement and claims processing, although reimbursement will be made according to the TRICARE-allowable charge. Hospitals, birthing centers, and ambulatory surgery centers (ASCs) reporting outpatient services on a *UB-04*, 837I or Web submittal should indicate the HCPCS codes that best describe the services rendered in FL 44 or the electronic equivalent, as applicable. HCPCS Level I codes, Level II codes, and revenue codes are required for all services except supplies and some drugs. HCPCS Level II codes are required for drugs administered by injection or infusion, but not for other prescription drugs.

Some surgical procedures may not be found in any level of HCPCS. Typically, these are services that are rarely provided, or are unusual, variable, or unlisted procedures. In order for UnitedHealthcare to make an appropriate benefit determination, all care billed with unlisted codes must include descriptions of the items and pricing, if

available, and have prior authorization. Claims with unlisted codes must contain an item number or a National Drug Code, if appropriate. If it is determined that an adequately descriptive code is contained in HCPCS, PGBA will return the claim to the provider for the appropriate HCPCS/CPT code. If, after review, the determination is that no existing code sufficiently describes the procedure, PGBA will process the claim according to the documentation submitted and reimburse the claim according to the UnitedHealthcare Fee Schedule found at [uhcmilitarywest.com](http://uhcmilitarywest.com) under the “Reimbursement Rates” link. HCPCS includes 2 levels of codes and modifiers:

- **Level I:** the numeric CPT codes used by the American Medical Association
- **Level II:** alphanumeric codes for physician and other provider services not included in CPT (e.g., ambulance, DME, orthotics, and prosthetics)

All provider specialties and types of institutions (except those listed in Figure 8.3 below), must report HCPCS codes on institutional claims. Outpatient hospital services must be billed on a *UB-04*; they cannot be billed on a *CMS-1500*, *837P* or website using the SG modifier.

**Institutional Reporting Code Types**

**Figure 8.3**

Institution	Code Type
Christian Science Sanatoria	Revenue Codes
Dentists and dental services	American Dental Association® Current Dental Terminology Codes
Pharmacies	National Drug Codes
Residential treatment centers	Revenue Codes
Skilled nursing facilities	Revenue Codes

For related information, see “Outpatient Prospective Payment System” in the *TRICARE Reimbursement Methodologies* section of this Handbook.

## Proper Treatment Room Billing

Under the TRICARE OPPTS reimbursement methodology, payment of 0510 and 0760 series revenue codes are based on the HCPCS codes billed on the claim.

### Revenue Code 076X

Determining when to use revenue code 076X (treatment or observation room) to indicate use of a treatment room may be confusing, and improper coding may lead to inappropriate billing.

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:

- An 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 076X should not be used when the claim is submitted with a type of bill 083X and ASC procedure codes. ASC facility services are reimbursed under the ASC grouper reimbursement or OPPTS.

### Revenue Code Series 051X

Figure 8.4 lists revenue codes that are reimbursed for facilities billing with revenue code series 051X.

Code	Description
510	Clinic, general class
511	Clinic, chronic pain
512	Clinic, dental (not payable for TRICARE)
513	Clinic, psychiatric
514	Clinic, OBGYN
515	Clinic, pediatric
516	Reserved
517	Clinic, family practice
518	Reserved
519	Clinic, other

## Billing with ICD-9 V Codes or ICD-10 Z Codes

It is very important to use the proper V codes (when applicable) for claims reimbursement. A V code may designate a primary diagnosis for an outpatient claim that explains the reason for a patient's visit to your office. V codes should be used for preventive or other screening claims; all other claims should be billed with the standard numeric ICD-9 diagnosis codes. Note: TRICARE policy defines V-code diagnoses as "conditions not attributable to a mental disorder." Therefore, V code diagnoses for TRICARE behavioral health care services are **not** covered. V codes also should not be used for routine physical examinations, although a V code may be billed in conjunction with other valid codes. For services on or after October 1, 2014, use the relevant Z codes.

### Choose the Correct ICD-9 V Code or ICD-10 Z Code

For dates of service prior to October 1, 2014, use the correct V-code diagnosis to indicate the reason for the visit. For dates of service on or after October 1, 2014, use the correct Z code (see [Figure 8.5](#)). The V or Z code must match the CPT/HCPCS code to indicate the procedure that you are performing as it correlates to the V code or Z code diagnosis. If you bill vague diagnosis codes, they will not be paid.

### How to Bill with V Codes (for Dates of Service Prior to October 1, 2014)

V codes correspond with descriptive, generic, preventive, ancillary, or required medical services and should be billed accordingly.

#### Descriptive V Codes

For V 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 V code includes a routine infant or child health visit, which is designated as V20.2.

#### Generic V Codes

For generic non-payable services, such as lab, radiology, or pre-op, a generic V code should not be used as a primary diagnosis. Rather, the underlying medical condition should be listed as the primary diagnosis for these ancillary services.

#### Preventive V Codes

For preventive services, a V 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 a mammogram, a Pap smear, or a fecal occult blood screening.

Figure 8.5 on the following page lists clinical preventive services and the corresponding V codes.

## How to Bill with Z Codes (for Dates of Service on or after October 1, 2014)

Z codes correspond with descriptive, generic, preventive, ancillary, or required medical services and should be billed accordingly.

### 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 includes a routine infant or child health visit, which is designated as Z00.121, Z00.129, Z00.2, Z00.70, or Z00.71.

### Generic Z Codes

For generic non-payable services, such as lab, radiology, or pre-op, a generic Z code should not be used 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 a mammogram, a Pap smear, or a fecal occult blood screening. Figure 8.5 lists clinical preventive services and the corresponding Z codes.

**Clinical Preventive Services ICD-9 V Codes and ICD-10 Z Codes**

**Figure 8.5**

Preventive Service	Proper V Codes (before 10/1/2014)	Proper Z Codes (on or after 10/1/2014)	Care Intervals and Notes
<b>Colonoscopy</b>	V76.51	Z12.11 Z80.0 (if applicable)	<p><b>Individuals at average risk for colon cancer:</b></p> <ul style="list-style-type: none"> <li>• Colonoscopy covered once every 10 years beginning at age 50.</li> </ul> <p><b>Individuals at increased risk for colon cancer:</b></p> <ul style="list-style-type: none"> <li>• Colonoscopy once every 5 years for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp before age 60, or in 2 or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at either 40 or 10 years younger than the earliest affected relative, whichever is earlier.</li> <li>• Colonoscopy once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in 2 second-degree relatives.</li> </ul> <p><b>Individuals at high risk for colon cancer:</b></p> <ul style="list-style-type: none"> <li>• Colonoscopy once every 1 to 2 years for individuals with a genetic or clinical diagnosis of hereditary non-polyposis colorectal cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20–25 or 10 years younger than the earliest age of diagnosis, whichever is earlier.</li> <li>• For individuals diagnosed with inflammatory bowel disease, chronic ulcerative colitis, or Crohn’s disease, cancer risk begins to be significant 8 years after the onset of pancolitis or 10–12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every 1 to 2 years with biopsies for dysplasia.</li> <li>• There are no copayments or cost-shares required for TRICARE Prime or TRICARE Standard and TRICARE Extra beneficiaries.</li> </ul> <p>Note: Computed tomographic colonography (CTC) is covered as a colorectal cancer screening only when an optical colonoscopy is medically contraindicated or cannot be completed due to a known colonic lesion or structural abnormality, or when other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is not covered as a colorectal cancer screening for any other indication or reason.</p>



Preventive Service	Proper V Codes (before 10/1/2014)	Proper Z Codes (on or after 10/1/2014)	Care Intervals and Notes
<b>Mammograms</b>	V76.10 V76.11 V76.12	Z12.31	<p>Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15% or greater lifetime risk of breast cancer (<i>according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model</i>), or who have any of the following risk factors:</p> <ul style="list-style-type: none"> <li>• History of breast cancer, Ductal Carcinoma In Situ, Lobular Carcinoma In Situ, Atypical Ductal Hyperplasia, or Atypical Lobular Hyperplasia</li> <li>• Extremely dense breasts when viewed by mammogram</li> <li>• Known BRCA1 or BRCA2 gene mutation<sup>1</sup></li> <li>• First-degree relative (<i>parent, child, sibling</i>) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves<sup>1</sup></li> <li>• Radiation therapy to the chest between ages 10 and 30</li> <li>• History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of 1 of these syndromes<sup>1</sup></li> </ul> <p>There are no copayments or cost-shares for TRICARE Prime or TRICARE Standard and TRICARE Extra beneficiaries.</p> <p>Note: The mammogram and add-on codes must be submitted on the same claim if performed on the same date of service.</p>
<b>Optometry (eye examinations)</b>	V72.0	Z01.00 Z01.01	<p><b>Active duty service members ADSMs:</b></p> <ul style="list-style-type: none"> <li>• TRICARE Prime ADSMs must receive all vision care at a military treatment facility (MTF) unless specifically referred to a network provider (<i>or non-network provider if a network provider is not available</i>).</li> <li>• TRICARE Prime Remote ADSMs may obtain comprehensive eye examinations from network providers as needed to maintain fitness-for-duty status without authorization.</li> </ul> <p><b>Active duty family members (ADFM):</b></p> <ul style="list-style-type: none"> <li>• 1 routine eye examination to check for vision and diseases within a 12 month period, regardless of TRICARE program option.</li> <li>• Medically necessary care for injuries to the eye is covered.</li> </ul> <p><b>Retired service members and their dependents:</b> (<i>includes all beneficiaries other than ADSMs and ADFMs</i>)</p> <ul style="list-style-type: none"> <li>• If enrolled in TRICARE Prime, 1 routine eye examination to check for vision and diseases every 2 years (<i>except for diabetic patients, see "Diabetic patients" later in this figure</i>).</li> <li>• If using TRICARE Standard and TRICARE Extra or TRICARE For Life, no coverage (<i>except for well-child benefit and diabetic patients, see "Well-child benefit" and "Diabetic patients" later in this figure</i>).</li> <li>• Medically necessary care for injuries to the eye is covered.</li> </ul> <p><b>Well-child benefit:</b> For all TRICARE-eligible infants and children up to age 6:</p> <ul style="list-style-type: none"> <li>• Infants may receive 1 eye and vision screening<sup>2</sup> during routine examinations at birth and at approximately 6 months under the well-child benefit. Use V20.2, Z00.121, or Z00.129 for eye examinations under the well-child benefit.</li> <li>• Children may receive 2 pediatric routine eye exams<sup>2</sup> between ages 3 and 6 under the well-child benefit (<i>use V20.2, Z00.121, or Z00.129</i>).</li> </ul> <p><b>Diabetic patients:</b></p> <ul style="list-style-type: none"> <li>• Diabetic patients at any age are allowed 1 routine eye examination each calendar year.</li> </ul> <p>Note: For TRICARE Prime enrollees, a primary care manager (PCM) or UnitedHealthcare referral is not needed, but TRICARE Prime beneficiaries must see an MTF or network optometrist or ophthalmologist. The V or Z code can be used for the annual examination; however, if a medical condition is identified, use medical diagnosis Current Procedural Terminology (CPT®) codes.</p>

Preventive Service	Proper V Codes (before 10/1/2014)	Proper Z Codes (on or after 10/1/2014)	Care Intervals and Notes
<b>Pap smear</b>	V72.31 V72.32 V76.2 V76.47	Z01.411 Z01.419 Z12.4	Annually for women over age 18 ( <i>younger if sexually active</i> ) until 3 consecutive satisfactory normal annual examinations. Frequency may then be less often at the discretion of the patient and clinician, but not less frequently than every 3 years. No PCM or UnitedHealthcare referral or copayment are required for TRICARE Prime beneficiaries who use network providers.
<b>Procto-sigmoidoscopy/sigmoidoscopy</b>	V76.51	Z12.11 Z80.0 ( <i>if applicable</i> )	<p><b>Individuals at average risk for colon cancer:</b></p> <ul style="list-style-type: none"> <li>• Proctosigmoidoscopy/sigmoidoscopy once every 3 to 5 years beginning at age 50.</li> </ul> <p><b>Individuals at increased risk for colon cancer:</b></p> <ul style="list-style-type: none"> <li>• Proctosigmoidoscopy/sigmoidoscopy once every 5 years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or 2 second-degree relatives.</li> </ul> <p><b>Individuals at high risk for colon cancer:</b></p> <ul style="list-style-type: none"> <li>• Annual flexible sigmoidoscopy, beginning at age 10–12, for individuals with known or suspected familial adenomatous polyposis.</li> </ul>
<b>Regular immunizations</b>	V20.2 ( <i>includes well-child check</i> ) V03.XX V04.XX V05.XX V06.XX	Z00.121 Z00.129 Z00.2 Z00.70 Z00.71 Z23	<p>Immunizations should be administered at age-appropriate doses as suggested by the current schedule of recommended vaccines for use in the United States by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices at CDC.gov.</p> <p>Note: Immunizations recommended specifically for travel outside the United States are not covered, except for immunizations required for ADFMs whose sponsors have permanent change-of-station orders to overseas locations, which are covered as outpatient office visits.</p>
<b>School physicals</b> ( <i>Note: Sports-related physical examinations are not a covered benefit.</i> )	V70.3	Z02.0	<ul style="list-style-type: none"> <li>• TRICARE-eligible dependents who are at least age 5 and less than age 12 may get physical examinations that are required by a school in connection with the enrollment of the dependent as a student in that school. This benefit does not include physical examinations that may be required by the school to participate in school sports, as they are not considered benefits. Physicals for children age 12 and older are authorized only if the physical is required.</li> <li>• TRICARE Prime beneficiaries do not have copayments when using network providers.</li> <li>• TRICARE Standard and TRICARE Extra beneficiaries will pay the applicable cost-share and deductibles.</li> </ul>
<b>Well-child visits</b>	V20.2	Z00.121 Z00.129 Z00.2 Z00.70 Z00.71	<ul style="list-style-type: none"> <li>• Includes routine newborn care, comprehensive health promotion (<i>birth to age 6</i>) and disease-prevention examinations, vision and hearing screenings, height/weight/head circumference, routine immunizations (<i>according to CDC guidelines</i>), and developmental/behavioral appraisals (<i>according to American Academy of Pediatrics®</i>).</li> <li>• Copayments or cost-shares are not required of TRICARE Prime or TRICARE Standard and TRICARE Extra beneficiaries.</li> </ul>

1. Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

2. Infant screening includes visual acuity, ocular alignment, red reflex, and external examination.

3. Pediatric routine eye examination includes amblyopia and strabismus examination.

## Processing Claims for Out-of-Region Care

If you have treated a TRICARE patient from another TRICARE region, submit the claims to the TRICARE region where the beneficiary resides and/or is enrolled in TRICARE Prime for faster payment. TRICARE pays based on where the beneficiary resides or is enrolled (except when care is received overseas), whereas Medicare pays based on where the services are rendered.

For example, if a provider in the West Region cares for a TRICARE Prime, TPR, or TPRADFM beneficiary from a state located in the North Region or the South Region, the provider should submit the claim to the

responsible contractor for that region to expedite payment. PGBA can forward the claim to the appropriate region, but it may result in a delay in payment. If the claim is filed electronically to PGBA, the claim will be electronically forwarded to the appropriate region.

**North Region (877) TRICARE/(877) 874-2273**

The North Region includes Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Iowa (Rock Island Arsenal area only), Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri (St. Louis area only), New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee (Fort Campbell area only), Vermont, Virginia, West Virginia, and Wisconsin.

Paper claims should be sent to:

Health Net Federal Services, LLC  
 c/o PGBA Claims  
 P.O. Box 870140  
 Surfside Beach, SC 29587-9740

**South Region (800) 403-3950**

The South Region includes Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee (excluding the Ft. Campbell area), and Texas (excluding the El Paso area).

Paper claims should be sent to:

PGBA South Region Claims Department  
 P.O. Box 7031  
 Camden, SC 29020-7031

**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 USFHP. The USFHP is offered in 6 geographic regions in the United States. Although it provides the TRICARE Prime benefit, the USFHP is a separately funded program different from the TRICARE program administered by UnitedHealthcare. The designated provider is at full risk for all medical care for a USFHP enrollee, including pharmacy services, primary care, and specialty care.

If you provide care to a USFHP enrollee outside the network or in an emergency situation, claims must be filed with the appropriate designated provider at one of the addresses listed in Figure 8.6. Do **not** file USFHP claims with UnitedHealthcare. For more information about the USFHP, visit **USFHP.com**.

**USFHP Designated Providers**

**Figure 8.6**

<p><b>Martin’s Point Health Care</b>          ATTN: Claims          P.O. Box 11410          Portland, ME 04104-7410</p>	<p><b>Johns Hopkins Medical Services Corporation</b>          US Family Health Plan/TRICARE ATTN: Claims Department          P.O. Box 33          Glen Burnie, MD 21060</p>
<p><b>Brighton Marine Health Center</b>          ATTN: USFHP Claims          P.O. Box 9195          Watertown, MA 02479195</p>	<p><b>CHRISTUS Health</b>          US Family Health Plan          ATTN: Claims          P.O. Box 924708          Houston, TX 77292-4708</p>
<p><b>St. Vincent Catholic Medical Centers of New York</b>          US Family Health Plan at SVCMC ATTN: Claims          P.O. Box 830745          Birmingham, AL 35283-0745</p>	<p><b>Pacific Medical Clinics</b>          1200 12th Avenue South, Quarters 8 &amp; 9          Seattle, WA 98144-2790</p>

## TRICARE Overseas/Foreign Claims

International SOS Assistance, Inc. (International SOS) administers the TRICARE program overseas and handles claims processing for all overseas claims, regardless of where the beneficiary is enrolled. If filing a claim for an ADSM who is enrolled in a TRICARE Overseas Program (TOP) option (TOP Prime or TOP Prime Remote), submit it to the address listed in Figure 8.7. If filing a claim for a non-ADSM in a TOP option, submit it to one of the addresses listed in Figure 8.8.

Note: This includes TFL claims for medical care received outside the United States and its territories.

**TRICARE Overseas Claims Contact Information—ADSMs** **Figure 8.7**

<b>All overseas areas</b>	TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968
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**TRICARE Overseas Claims Contact Information—Non-ADSMs** **Figure 8.8**

<b>TRICARE Eurasia-Africa</b> ( <i>Africa, Europe, and the Middle East</i> )	TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976 (877)-678-1207
<b>TRICARE (Pacific Latin America and Canada)</b> ( <i>Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands</i> )	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 (877)-451-8659
<b>TRICARE Pacific</b> ( <i>Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries</i> )	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 Singapore: (877)-678-1208 Sydney: (877)-678-1209

Overseas claims for National Guard and Reserve members on orders of 30 days or less should also be sent to International SOS. 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. Fax the forms and attachments to (608) 301-2251.

For more information on filing claims for TOP beneficiaries, visit [tricare-overseas.com/provider](http://tricare-overseas.com/provider) → TOP Claims Submission Guidelines.

## Claims for Beneficiaries Using Medicare and TRICARE

WPS is the claims processor for all TFL claims.

Note: While WPS is the claims processor for the West Region, claims are filed differently for beneficiaries eligible for both TRICARE and Medicare. UnitedHealthcare cannot provide claims information for these beneficiaries.

If you currently submit claims to Medicare on your patients' behalf, you will not need to submit claims to WPS. WPS has signed agreements with each Medicare carrier allowing them to submit claims directly to WPS for TRICARE beneficiaries, regardless of age. Claims processed by Medicare are submitted electronically to WPS/TFL. Beneficiaries and providers will receive remittance advices from WPS/TFL once processing has been completed. If you do not participate in Medicare, or the services you perform are not Medicare benefits, you will need to submit paper claims to WPS/TFL.

Note: Participating providers accept Medicare’s allowable amount. Nonparticipating providers do not accept Medicare’s payment amount and are permitted to charge up to 115% of the Medicare-allowable amount. Both participating and nonparticipating providers may bill Medicare.

When TRICARE is the primary payer, all TRICARE requirements apply. Refer to the *TRICARE Reimbursement Manual*, Chapter 4 <http://manuals.tricare.osd.mil> for details.

Figure 8.9 contains important contact information for you or your patients regarding TRICARE and Medicare claims.

**TRICARE and Medicare Claims Contact Information**

**Figure 8.9**

<b>Claims submission</b> ( <i>Note: Submit claims to Medicare first.</i> )	WPS TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890
<b>Customer service</b>	WPS TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889
<b>Online</b>	TRICARE4u.com
<b>Toll-free telephone</b>	(866) 773-0404
<b>Toll-free TDD</b>	(866) 773-0405

**Claims for NATO Beneficiaries**

TRICARE covers the North Atlantic Treaty Organization (NATO) foreign nations’ armed forces members who are stationed in the United States or are in the United States at the invitation of the U.S. Government. The benefits are the same as for American ADSMs, including no out-of-pocket expenses for care that is directed by the MTF.

Eligible family members of active duty members of NATO nations who are stationed in or passing through the United States in connection with their official duties are eligible for outpatient services under TRICARE Standard and TRICARE Extra. A copy of the family member’s identification card will have a Foreign Identification Number (issued by the DEERS) and indicate on the reverse “Outpatient Services Only.”

NATO family members do not need MTF referrals prior to receiving outpatient services from civilian providers. NATO family members follow the same prior authorization requirements as TRICARE Standard and TRICARE Extra beneficiaries. Like all TRICARE Standard and TRICARE Extra beneficiaries, NATO family members are responsible for TRICARE Standard and TRICARE Extra deductibles and cost-shares. To collect charges for services not covered by TRICARE, you must have the NATO beneficiary agree, in advance and in writing, to accept financial responsibility for any non-covered service. You may obtain a copy of the *Waiver of Non-Covered Services* form at [uhcmilitarywest.com](http://uhcmilitarywest.com) → Find a Form → General.

NATO claims for ADSMs and ADFMs should be filed electronically the same way other TRICARE claims are submitted. If claims are submitted by mail, submit to:

TRICARE West Region  
Claims Department  
P.O. Box 7064  
Camden, SC 29020 -7064

TRICARE will not cover inpatient services for NATO beneficiaries. In order to be reimbursed for inpatient services, the NATO beneficiary should make the appropriate arrangements with the NATO nation embassy or consulate in advance.

Eligibility for NATO beneficiaries is maintained in DEERS and is available on the secure website at [uhcmilitarywest.com](http://uhcmilitarywest.com). Claims submission procedures are the same as for American ADFMs.

## Claims for CHAMPVA

CHAMPVA is not a TRICARE program. For questions or general correspondence, you may contact CHAMPVA by any of the means listed in Figure 8.10.

**CHAMPVA Contact Information**

**Figure 8.10**

<b>Phone</b>	(800) 733-8387
<b>Mail</b>	VA Health Administration Center CHAMPVA P.O. Box 469063 Denver, CO 80246-9063
<b>website</b>	<a href="http://www.va.gov/hac/forproviders">www.va.gov/hac/forproviders</a>

Claims for current treatment must be filed within 365 days of the date of service. Providers may file health care claims on behalf of their patients. If you wish to file a paper health care claim, CHAMPVA claim forms may be downloaded from the CHAMPVA website. To file a paper health care claim within the 1-year filing deadline, send the claim to:

VA Health Administration Center  
CHAMPVA  
P.O. Box 469064  
Denver, CO 80246-9064

Written appeals may be requested if exceptional circumstances prevented you from filing a claim in a timely fashion. Send written appeals to:

VA Health Administration Center  
CHAMPVA  
ATTN: Appeals  
P.O. 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, PGBA will forward CHAMPVA claims to the CHAMPVA VA Health Administration Center within 72 hours of identification as a 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 VA Health Administration Center.

## Claims for CHCBP

Humana Military Healthcare Services, Inc. is the contractor for CHCBP and has contracted with PGBA for processing non-overseas CHCBP claims. For questions and assistance regarding CHCBP claims, please call PGBA at (800) 403-3950. UnitedHealthcare will not be able to answer any questions about CHCBP claims.

CHCBP beneficiaries may request that you file medical claims on their behalf. File CHCBP claims electronically at [myTRICARE.com](http://myTRICARE.com). File all paper claims at one of the addresses listed in Figure 8.11.



<p><b>CHCBP Behavioral Health Claims</b>                  P.O. Box 7034                  Camden, SC 29020-7034</p>
<p><b>All other CHCBP Claims</b>                  P.O. Box 7031                  Camden, SC 29020-7031</p>

**Claims for ECHO**

All TRICARE ECHO claims must have a valid written authorization. All claims for ECHO-authorized care (including ECHO Home Health Care) shall be billed on individual line items. Unauthorized ECHO claims will be denied.

ECHO claims will be reimbursed for the amount authorized to the fiscal year benefit limit. 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 must reflect the service, not the applicable ECHO benefit limits. Pricing of ECHO services and items is determined in accordance with the *TRICARE Reimbursement Manual* at <http://manuals.tricare.osd.mil>.

Please note that claims for the DoD Enhanced Access to Autism Services Demonstration should be processed per the instructions on the TRICARE regional contractor’s website. These claims use special procedure codes and require special certification.

**Claims for the SHCP**

Claims for the SHCP are processed and paid through PGBA.

The same balance billing limitations applicable to TRICARE apply to the SHCP. For more information regarding balance billing, see the *Important Provider Information* section of this Handbook.

**Claims for TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult**

For individuals covered under TRS, follow the applicable cost-shares, deductibles, and catastrophic caps for ADFMs using TRICARE Standard and TRICARE Extra. For additional information, visit [uhcmilitarywest.com](http://uhcmilitarywest.com).

For individuals covered under TRR, follow the applicable cost-shares, deductibles, and catastrophic caps for TRICARE retirees using TRICARE Standard and TRICARE Extra. For additional information, visit [uhcmilitarywest.com](http://uhcmilitarywest.com).

TYA Standard has the same cost-shares as TRICARE Standard and TRICARE Extra and contributes to individual and family deductibles and to the family’s catastrophic cap. Deductibles and cost-shares for TYA beneficiaries are based on their sponsor’s status. If the sponsor is an ADSM or TRS member, ADFM cost-shares apply. If the sponsor is a retiree or TRR member, retiree cost-shares apply. For additional information, visit [uhcmilitarywest.com](http://uhcmilitarywest.com).

**TRICARE Network Providers**

Claims must be filed electronically with PGBA on behalf of TRS, TRR and TYA members in the same manner as other TRICARE West Region claims.

## Non-Network TRICARE-Authorized Providers

Participation with TRICARE (e.g., accepting assignment, filing claims, accepting the TRICARE-allowable charge as payment in full) is encouraged, but not required.

If a non-network provider does not participate on a particular claim, members will file their own claims with TRICARE for reimbursement and then pay the non-network provider.

By federal law, if a non-network provider does not participate on a particular claim, the provider may not charge beneficiaries more than 15% above the TRICARE-allowable charge.

The TRICARE-allowable charge schedules can be found at [www.tricare.mil/cmac](http://www.tricare.mil/cmac).

## TRICARE and Other Health Insurance (OHI)

TRICARE is the last payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other programs or plans as identified by TMA.

TRICARE beneficiaries who have OHI are not required to obtain referrals or prior authorizations for covered services, except in the case of the services listed in Figure 8.12, which continue to require prior authorization even when OHI coverage exists.

### **OHI: Services Requiring TRICARE Prior Authorization Figure 8.12**

• ECHO services
• Solid organ and stem-cell transplants

You are encouraged to ask the beneficiary about OHI so that benefits can be coordinated. Since OHI status can change at any time, it is important to obtain this information from the beneficiary on a routine basis, including family members of activated National Guard and Reserve members. If a beneficiary's OHI status changes, make sure to update patient billing system records to avoid delays in claim payments. If you indicate that there is no OHI, but DEERS indicates otherwise, a signed or verbal notice from the beneficiary will be required to inactivate the OHI record. To update OHI information, beneficiaries may complete the *TRICARE Other Health Insurance (OHI)* Form available at [UhcMilitaryWest.com](http://UhcMilitaryWest.com) → Find a Form → General.

## Submitting Other Health Insurance Claims

You should submit claims with OHI electronically. You do not need to attach the primary payer's remittance advice. If you are unable to submit your claim electronically, the remittance advice from the primary insurer must accompany your claim submission to PGBA. Be sure to include the following information:

- The amount paid by the other insurer
- The amount you need to write off according to the OHI's policies
- A copy of the primary insurer's remittance advice with TRICARE paper claims; the primary insurer's remittance advice must contain the following:
  - The definition of any "reason codes" used by the primary payer to describe how the claim was processed, when applicable
  - Information on the action taken by the primary payer for each specific date of service and charges, when applicable

Claims submitted without the listed information will be denied.

Note: UnitedHealthcare pays claims with OHI line by line. If the other carrier pays on some lines and not others, UnitedHealthcare will consider each service on its own merit.

## **TRICARE Prime Point-of-Service Option (POS)**

POS cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. However, it is required that the beneficiary have prior authorization for certain covered services, whether or not the beneficiary has OHI (previously listed in Figure 8.12). For additional information please refer the *Point-of-Service* section in this Handbook.

## **Calculating Payments**

Payments from the primary payer and TRICARE (as the secondary payer) will not collectively exceed the billed charges.

OHI payments will not exceed the beneficiary liability. TRICARE will pay the beneficiary liability unless that amount is more than the TRICARE-allowable charge.

Visit [uhcmilitarywest.com](http://uhcmilitarywest.com) and see the “Claims/Payments” page for additional information on OHI calculations.

## **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 actions must be taken that can affect total processing time. UnitedHealthcare is responsible for identifying and investigating all potential third-party recovery claims.

Inpatient claims submitted with diagnosis codes indicating a potential accidental injury or illness will be researched regardless of the billed amount. Claims for professional services that exceed a TRICARE liability of \$500 will also be researched. These claims will not be processed further until the beneficiary completes and submits a *Statement of Personal Injury – Possible Third Party Liability (DD Form 2527)*. Providers may wish to print a *DD Form 2527* from [UhcMilitaryWest.com](http://UhcMilitaryWest.com) → Find a Form → General to facilitate the completion of the form by the beneficiary. There are certain diagnosis codes that are exceptions to the *DD Form 2527* submission requirement.

When the claim is received and appears to have possible third-party involvement, as mentioned previously, the following process will occur:

- The *DD Form 2527* will be mailed to the beneficiary.
- The claim is pended for up to 35 calendar days. If the *DD Form 2527* is not received, the claim may be denied.

The claim will be reprocessed when the *DD Form 2527* is completed and returned by the beneficiary. Encourage the beneficiary to fill out the form within the 35 calendar days to avoid payment delays. If the illness or injury was not caused by a third party, but the diagnosis code(s) still falls between 800 and 999 for ICD-9 coding or for ICD-10 codes use S00.00 and T88.9 and ending in the seventh character A, B, or C (indicating initial encounter), the beneficiary may still be responsible to fill out the *DD Form 2527*. If the form is not returned, the claim will be denied.

If the claim is denied due to lack of submission of the *DD Form 2527* by the beneficiary, you may bill the beneficiary.

When the medical records demonstrate that there is no potential for third-party liability and the beneficiary or next of kin has refused to complete the *DD Form 2527* or cannot be located by the provider, there is no need to submit a completed *DD Form 2527* before the claims are processed. If the *DD Form 2527* is not returned and the provider states that there is no potential for third-party liability, UnitedHealthcare shall request copies of medical

records. If UnitedHealthcare's review of the records determines that no potential third-party liability exists, the claim may be processed and paid without a completed *DD Form 2527*.

## **TRICARE and Workers' Compensation**

TRICARE will not share costs for services for work-related illnesses or injuries that are covered under workers' compensation programs.

## **Avoiding Collections Activities**

Both network and non-network providers are encouraged to explore every possible means to resolve claims issues without involving debt-collection agencies. The most important action you can take for your practice and for TRICARE beneficiaries is to avoid the debt-collection process altogether by following these simple error-checking steps:

1. Review the TRICARE remittance advice when it arrives; if a claim is rejected, it will state the reason.
2. If the remittance advice states that inaccurate beneficiary information is the reason for the denial, it is important to make every attempt to contact the beneficiary to obtain the correct information.
3. If a remittance advice does not arrive within 30 days, this may mean that there has been a problem in submission of the claim. Registered users of [uhcmilitarywest.com](http://uhcmilitarywest.com) may check claims status online. If the patient has Medicare, contact the TRICARE dual-eligible fiscal intermediary, PGBA at (877) 988-WEST/(877) 988-9378.
4. Secure website users may submit additional or corrected information regarding a rejected claim. For more information, refer to the "Claims/Payments" Web page at [uhcmilitarywest.com](http://uhcmilitarywest.com).

Use the secure area of [uhcmilitarywest.com](http://uhcmilitarywest.com) to verify claims status. Please wait at least 30 days after submitting a claim before contacting UnitedHealthcare. After 30 days you may find assistance on the secure website at [uhcmilitarywest.com](http://uhcmilitarywest.com) or by calling (877) 988-WEST/(877) 988-9378. Otherwise, network and non-network providers should contact their local TRICARE representatives.

Beneficiaries are responsible for their out-of-pocket expenses. A beneficiary should not be sent to collections before the non-network provider contacts his or her local TRICARE representative, unless the only amount outstanding is the beneficiary's deductible, cost-share, or copayment amount reflected on the provider remittance advice.

## **TRICARE Reimbursement Methodologies**

Reimbursement rates and methodologies are subject to change per DoD guidelines. Refer to the *TRICARE Reimbursement Manual* at <http://manuals.tricare.osd.mil> for more information. Providers must use applicable modifiers that fit the description of the service. The CPT and HCPCS publications contain lists of modifiers available for describing services.

## **Reimbursement Limit**

Payments made to network providers for medical services rendered to TRICARE beneficiaries shall not exceed 100% of the TRICARE-allowable charges.

## **CHAMPUS Maximum Allowable Charge**

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) maximum allowable charge (CMAC) is the maximum amount TRICARE will reimburse for nationally established procedure coding (i.e., codes for professional services). CMAC is the TRICARE-allowable charge for covered services when

appropriately applied to services priced under CMAC.

### **Site-of-Service Pricing**

TRICARE CMAC changes are variable at the discretion of TMA. The following 4 categories represent the 4 classes of providers used for reimbursement:

**Category 1:** Services of medical doctors (MDs), doctors of osteopathy (DOs), optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, audiologists, and applicable outpatient hospital services provided in a facility, including:

- Ambulances
- Ambulatory surgery centers (ASCs)
- Community mental health centers
- Hospices
- Hospitals (both inpatient and outpatient where the hospital is generating a revenue bill; i.e., revenue code 510)
- MTFs
- Psychiatric facilities
- Residential treatment centers
- Skilled nursing facilities (SNFs)

**Category 2:** Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists, and applicable outpatient hospital services **provided in a non-facility**, including:

- Home settings
- Provider offices
- Other non-facility settings

**Category 3:** Services of all other providers not found in Category 1 provided in a facility.

**Category 4:** Services of all other providers not found in Category 2 provided in a non-facility.

UnitedHealthcare will retain and maintain previous years' CMAC files for historical purposes. Updated CMAC rates based on site of service are available on the TRICARE website at [www.tricare.mil/cmac](http://www.tricare.mil/cmac). Periodic CMAC changes apply to both network and non-network providers.

### **CHAMPUS Maximum Allowable Charge Procedure Pricing Calculator**

To use the CMAC calculator, go to [www.tricare.mil/cmac](http://www.tricare.mil/cmac) and follow the online prompts. For previous years' CMAC rates, use the applicable Current Procedural Terminology (CPT®) code.

Questions about the pricing calculator application may be sent to **[Webmaster-CMAC@tma.osd.mil](mailto:Webmaster-CMAC@tma.osd.mil)**.

## TRICARE-Allowable Charge

The TRICARE-allowable charge is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The allowable charge is the lowest of:

(a) the actual billed charge; (b) the maximum TRICARE-allowable charge; or (c) the UnitedHealthcare Fee Schedule.

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 lower of the 2 charges).
- If the TRICARE-allowable charge for a service is \$90, and the billed charge is \$100, TRICARE will allow \$90 (the lower of the 2 charges).
- In the case of inpatient hospital payments, the specific hospital reimbursement method applies (e.g., the diagnosis-related group [DRG] rate 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 outpatient prospective payment system (OPPS), services will be subject to OPPS ambulatory payment classifications (APCs) where applicable.

UnitedHealthcare Fee Schedule rates are established for codes that have no current available CMAC pricing. The UnitedHealthcare Fee Schedule includes those charges that fall within the range of charges most frequently used in a state for a particular procedure or service. When no maximum allowable charge is available, a UnitedHealthcare Fee Schedule rate is developed for the state in which the service or procedure is provided. Unless a specific exception has been made, these rates are developed on:

- A statewide basis (Localities within states are not used, nor are UnitedHealthcare Fee Schedule rates developed for any area larger than individual states.)
- A non-specialty basis

UnitedHealthcare Fee Schedule rates are developed using a minimum of 8 claims submitted for reimbursement to TRICARE. The rate is determined for the service by placing all actual charges billed for the service in an array by ascending order. The lowest charge (in the array) that is high enough to include 80% of the cumulative charges (number of claims billed) is determined to be the UnitedHealthcare Fee Schedule rate. For more details, refer to the following:

- [mytricare.com](http://mytricare.com)
- [uhcmilitarywest.com](http://uhcmilitarywest.com)
- the *TRICARE Reimbursement Manual*, Chapter 5, Section 1 at <http://manuals.tricare.osd.mil>.

If a minimum of 8 claims has not been received, the prevailing rate can be determined through the use of information about the volume of business done by various providers or suppliers within the TRICARE West Region or through available price lists and supply catalogs.

Examples of codes that do not have a CMAC rate but may have a state prevailing rate include:

- Ambulance services
- G-codes (for procedures that do not have CPT codes)
- Q-codes (supplies for casts)
- S-codes (drugs, services, and supplies with no national codes). Note: With limited exceptions, TRICARE no longer accepts S (temporary) codes. See the No Government Pay Procedure Code List, which is available at [www.tricare.mil/nogovernmentpay](http://www.tricare.mil/nogovernmentpay) or at [uhcmilitarywest.com](http://uhcmilitarywest.com) under "Reimbursement Rates."



This reimbursement schedule allows providers to know the reimbursement rates for various non-CMAC codes in advance and supports that UnitedHealthcare applies consistent pricing. If CMAC rates are subsequently established for any codes on this reimbursement schedule, which had previously been set by UnitedHealthcare, the new CMAC rate will supersede and govern the reimbursement for these services. The reimbursement schedule will be updated as needed by UnitedHealthcare, or as new codes are added.

For most services, the reimbursement rate is based on the state/location where the services are provided. To find the reimbursement rate for a particular code that does not have a CMAC rate established:

- Access the reimbursement schedule at [uhcmilitarywest.com](http://uhcmilitarywest.com) under “Reimbursement Rates.”
- Open the “UnitedHealthcare Fee Schedule” link. Select the state for which you wish to view or export codes.
- Select the specific code or click on “Export Selected State’s Procedure Codes.”

Visit [uhcmilitarywest.com](http://uhcmilitarywest.com) or call (877) 988-WEST/(877) 988-9378 for more information.

## Anesthesia Rates

TRICARE reimbursement of anesthesia services is calculated using the number of time units, the Medicare relative value units (RVUs), and the anesthesia conversion factor.

TRICARE allows for payment of anesthesia services using standard industry modifiers.

### Anesthesia Claims and Reimbursement

Professional anesthesia claims must be submitted on an appropriate *CMS-1500* form, using the applicable CPT anesthesia codes. If applicable, the claim must also be billed with the appropriate physical status (P) modifier. The use of other optional modifiers may also be appropriate. An anesthesia claim must specify who provided the anesthesia service. 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 services were provided by each provider. This distinction may be made by the use of modifiers.

### Calculating Anesthesia Reimbursement

The following formula is used to calculate the TRICARE anesthesia reimbursement:

$$\begin{aligned} &(\text{Time Units} + \text{RVUs}) \\ &\times \text{Conversion Factor} \end{aligned}$$

**Base unit:** TRICARE anesthesia reimbursement is determined by calculating a base unit, derived from the *Medicare Anesthesia Relative Value Guide*. A base unit includes reimbursement for:

- Preoperative examination of the beneficiary
- Administration of fluids and/or blood products incident to the anesthesia care
- Interpretation of non-invasive monitoring (e.g., electrocardiogram, temperature, blood pressure, oximetry, capnography, mass spectrometry)
- Determination of the required dosage/method of anesthesia
- Induction of anesthesia
- Follow-up care for possible postoperative effects of anesthesia on the beneficiary

Placement of arterial, central venous, and pulmonary artery catheters and use of transesophageal echocardiography are not included in the base-unit value. 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 determined in 15-minute increments. 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. Providers must indicate the number of time units in Column 24G (Days or Units) of the *CMS-1500* claim form.

**Conversion factor:** The sum of the time units and RVUs is multiplied by a conversion factor. Conversion factors differ between physician and non-physician providers and vary by state, based on local wage indexes.

For more specific information on anesthesia reimbursement calculation and methodologies, see the *TRICARE Reimbursement Manual* at <http://manuals.tricare.osd.mil>.

### **Anesthesia Procedure Pricing Calculator**

Visit [www.tricare.mil/anesthesia](http://www.tricare.mil/anesthesia) for an anesthesia rate calculator. You may also access the calculator from the “TRICARE Reimbursement Rates” page at [www.tricare.mil/provider](http://www.tricare.mil/provider).

### **Ambulatory Surgery Grouper Rates**

Freestanding ASCs and other providers exempt from TRICARE OPPS are reimbursed under the grouper rate methodology.

Ambulatory surgery facility payments fall into 1 of 11 TRICARE grouper rates. All procedures identified by TMA for reimbursement under this methodology can be found at [www.tricare.mil/ambulatory](http://www.tricare.mil/ambulatory). The rates established under this system apply only to the facility charges for ambulatory surgery.

### **Ambulatory Surgery Center Charges**

All hospitals and freestanding ASCs must submit claims for surgery procedures on a *UB-04* claim form.

### **Ambulatory Surgery Center Reimbursement**

All procedures are approved on the basis of medical necessity.

For additional information, ambulatory surgery providers may view reimbursements at [www.tricare.mil/ambulatory](http://www.tricare.mil/ambulatory). For a listing of TRICARE-grouped procedures, refer to [uhcmilitarywest.com](http://uhcmilitarywest.com). All groupers are defined by TMA at <http://www.tricare.mil/ambulatory> or at [www.tricare.mil/opps](http://www.tricare.mil/opps) depending on the hospital's reimbursement type.

Important points to remember about ASC groupers and reimbursement:

- Providers should bill the surgeries performed and not use unclassified codes.
- ASC groupers are priced based on CPT codes.
- TRICARE multiple surgery guidelines are based on the highest allowable and not ClaimCheck® guidelines.
- ASC claims are reimbursed based on a grouper rate or billed charges, as appropriate.
- UnitedHealthcare reimburses some services in addition to the grouper rate (e.g., certain labs, x-rays, implants). All services require appropriate CPT/Healthcare Common Procedure Coding System (HCPCS) coding. Unlisted codes require authorization and must include a complete description.

### **Surgeon's Services for Multiple Surgeries**

Multiple surgical procedures have specific reimbursement requirements. When multiple surgical procedures are performed, the primary surgical procedure (i.e., the surgical procedure with the highest allowable rate) will be paid at 100% of the contracted rate. Any additional covered procedures performed during the same surgical 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 little additional physician resources and/or is clinically

integral to the performance of the primary procedure. Payment for the incidental procedure is considered to be included in the payment of the primary procedure.

Certain codes are considered add-on, or modifier 51 exempt, procedures for non-OPPS professional and facility claims, which should not apply a reduction as a secondary procedure.

## **Diagnosis-Related Group Reimbursement (DRG)**

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 (PPS). Cases are classified into the appropriate DRG by a grouper program.

The grouper used for the TRICARE DRG-based payment system is the same as the Medicare grouper with some modifications such as neonate DRGs. Refer to the *TRICARE Reimbursement Manual* at <http://manuals.tricare.osd.mil> for detailed information.

TRICARE uses the TRICARE Severity DRG payment system, which is modeled on the Medical Severity DRG payment system. Present-on-admission indicators are required on all DRG claims. Hospital-acquired conditions, as identified by Medicare, will not be reimbursed.

Note: Critical access hospitals (CAHs) are reimbursed using the reasonable cost method, and are exempt from the DRG-based payment system. For more information, refer to the *TRICARE Reimbursement Manual*, Chapter 15, Section 1 at <http://manuals.tricare.osd.mil>.

### **Special Eligibility Rules under DRG**

Under the TRICARE Standard DRG payment system, if a patient loses or gains eligibility during a hospitalization, the DRG hospital will be paid as if the patient were eligible during the entire admission. If the patient becomes entitled to Medicare Part A and Medicare Part B coverage, Medicare is the first payer and TRICARE becomes the secondary payer. For a patient who becomes eligible for Medicare because of age, and who is not an ADFM, TRICARE's secondary pay status is for that claim only. However, a change in eligibility often will affect outlier payments. The patient's cost-share will be based on the status of the sponsor (active duty or retired) at the time of admission.

For all other providers, including DRG-exempt hospitals, TRICARE Standard will share the cost of only that portion of the services or supplies that were rendered before eligibility ceased.

### **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 as POA. Any hospital-acquired conditions, as identified by Medicare, will not be reimbursed. A list of hospital-acquired conditions can be found at [www.tricare.mil/drgrates](http://www.tricare.mil/drgrates).

Any claim that does not report a valid POA indicator for each diagnosis on the claim will be denied. The 5 valid POA codes are described in Figure 9.1.

POA Code	Description
<b>Y</b>	Indicates that the condition was present on admission.
<b>W</b>	Affirms that the provider has determined, based on data and clinical judgment, that it is not possible to document when the onset of the condition occurred.
<b>N</b>	Indicates that the condition was not present on admission.
<b>U</b>	Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
<b>1</b>	Prior to fiscal year (FY) 2011 ( <i>October 1, 2010–September 30, 2011</i> ), signifies exemption from POA reporting. Centers for Medicare and Medicaid Services established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the <i>ICD-9-CM Official Coding Guidelines</i> . FY 2011 and subsequent years, signifies unreported/not used. A list of exempt ICD-10-CM diagnosis codes is available in the <i>ICD-10-CM Official Coding Guidelines</i> for use for dates of service on or after October 1, 2014.

The following hospitals are exempt from POA reporting for TRICARE:

- CAHs
- Long-term care hospitals
- Cancer hospitals
- Children's inpatient hospitals
- Inpatient rehabilitation hospitals
- Psychiatric hospitals and psychiatric units
- Sole community hospitals (SCHs)
- VA hospitals

### DRG Calculator

The DRG calculator is available at [www.tricare.mil/drgrates](http://www.tricare.mil/drgrates).

You may locate the indirect medical education (IDME) factor (for teaching hospitals only) and wage index information using the Wage Indexes and IDME Factors File that are also available on the DRG Web page. If a hospital is not listed in the Wage Indexes and IDME Factors File, use the ZIP to Wage Index File to obtain the wage index for that area by ZIP code.

### Request for DRG Reimbursement Adjustment

If a DRG-reimbursed claim is submitted incorrectly, a hospital may request an adjustment by filing a corrected claim. Adjustment requests must be sent directly to PGBA within 60 days of the date the claim is processed. This date can be determined by looking at the remittance advice.

A change in the principal diagnosis or sequencing of the diagnosis or procedures may result in a higher-weighted DRG and a higher reimbursement rate. In these cases, the hospital provider should carefully review these cases. After review, providers who are registered users of [uhcmilitarywest.com](http://uhcmilitarywest.com) should submit their adjustment requests. The request and related information may be submitted to:

TRICARE West Region  
Correspondence Department  
P.O. Box 7065  
Camden, SC 29020 -7065

When submitting the adjustment rate, the hospital must also provide the following supporting documentation:

- A copy of the original remittance advice
- Corrections initialed and dated on the claim by facility billing staff
- The codes submitted for adjustment
- An explanation of why the original codes were submitted incorrectly
- A copy of the adjusted *UB-04*
- A copy of the medical record as required for performing admission review and DRG validation
- Copies of any newly acquired information on which coding changes are based

For more information, refer to the *TRICARE Reimbursement Manual*, Chapter 6, at <http://manuals.tricare.osd.mil>.

These rules apply only to claims submitted incorrectly by a provider. Only adjusted claims resulting in a higher-weighted DRG will be reviewed. Cases that do not regroup will be returned to the hospital without review.

### **Institutions Exempt from Medicare Prospective Payment System**

Hospitals excluded from the Medicare PPS also will be exempt from the TRICARE DRG reimbursement methodology for inpatient charges. Facilities excluded from the TRICARE DRG reimbursement methodology include the following:

- Cancer hospitals
- Christian Science sanatoria
- CAH
- Hospitals outside the 50 United States, the District of Columbia, or Puerto Rico
- Hospitals within hospitals
- Long-term care hospitals
- Psychiatric hospitals or units
- Rehabilitation hospitals or units
- Satellite facilities
- SCHs

### **Capital and Direct Medical Education Cost Reimbursement**

Facilities may request capital and direct medical education cost reimbursement. Capital items, such as 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.

All initial requests for reimbursement under capital and direct medical education costs must be submitted to PGBA on or before the last day of the 12th month following the close of the hospital's cost-reporting period. The request shall cover the 1-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, providers should report the following:

- 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 submission must include a statement certifying that any changes, if applicable, were made as a result of a review, audit, or appeal of the provider's Medicare cost report. The change(s) shall be reported to PGBA within 30 days of the date the hospital is notified of the change. Additionally, an officer or administrator of the provider must certify all cost reports. Providers should submit requests for reimbursement of capital and direct medical education costs to:

TRICARE West Region  
PGBA Finance, AG-740  
Capital and Direct Medical Education Reimbursement  
P. O. Box 100250  
Columbia, SC 29202

## **Bonus Payments in Health Professional Shortage Areas**

Network and non-network physicians (MDs and 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 behavioral health care providers who are eligible for HPSA bonuses are MDs and DOs. Non-physicians (e.g., PhDs, social workers, counselors, psychiatric nurse practitioners, marriage therapists) are not eligible.

Providers may determine if they are in an HPSA by accessing the U.S. Department of Health and Human Services, Bureau of Health Professions' HPSA search tool at <http://hpsafind.hrsa.gov>. There is also bonus payment information, including HPSA designations, on the CMS website at [www.cms.hhs.gov/HPSAPSAPhysicianBonuses](http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses).



## **How Bonus Payments Are Calculated**

For providers who are eligible and located in an HPSA, UnitedHealthcare's claims processor, PGBA will calculate a **quarterly** 10% bonus payment from the total paid amount for TRICARE claims that contain the modifier AQ (Health Professional Shortage Area) in Box 24D of the *CMS-1500* claim form. Bonus payments will be calculated on TRICARE Prime, TPR, TPRADFM, TRICARE Standard and TRICARE Extra, TRS, TRR, and TYA claims, and the amount paid by the government on other health insurance claims.

When submitting a claim for the bonus payment, providers must include the AQ CPT modifier in Box 24D of the *CMS-1500* claim form. For CPT codes with multiple modifiers, place the AQ modifier last. Only the professional component will be used in the calculation of the bonus payment for services that contain both a professional and technical component. Those providers who are eligible and do not submit claims with the appropriate modifier will not receive the bonus payment from TRICARE. There are no retroactive payments, adjustments, or appeals for obtaining a bonus payment, so include the bonus payment modifier with your initial claims submission if you are eligible.

Note: Although Medicare no longer requires the use of modifiers, TRICARE still requires their use. If claims are submitted without the modifier, your bonus payment cannot be paid.

## **Skilled Nursing Facility Pricing**

SNFs are paid using the Medicare PPS and consolidated billing. SNF PPS rates cover all routine, ancillary, and capital costs of covered SNF services. SNFs are required to perform resident assessments using the Minimum Data Set. SNF admissions require authorizations when TRICARE is the primary payer. Prior authorization is required for SNF admissions and continued stay reviews. Failure to obtain authorization or submit clinical information to complete the review upon request from UnitedHealthcare subjects the claim to a penalty. SNF admissions for children under age 10 and CAH swing beds are exempt from SNF PPS and are reimbursed based on DRG or contracted rates.

For more information about SNF PPS, refer to the *TRICARE Reimbursement Manual*, Chapter 8, Section 2 at <http://manuals.tricare.osd.mil>.

## **Home Health Agency Pricing**

TRICARE pays Medicare-certified home health agencies (HHAs) using a PPS modeled on Medicare's plan. Medicare-certified billing is handled in 60-day episodes of care, allowing HHAs to receive 2 payments of 60% and 40%, respectively, per 60-day cycle. This two-part payment process is repeated with every new cycle, following the patient's initial 60 days of home health care.

All home health services require prior authorization from UnitedHealthcare and renewal every 60 days. In order to receive private-duty nursing or additional nursing services/shift nursing, the TRICARE beneficiary may be enrolled in an alternative TMA-approved special program and a case manager must manage his or her progress.

### **Exceptions**

Beneficiaries enrolled in the Custodial Care Transition Program (CCTP) are exempt from Home Health PPS, and providers treating them may continue billing as always (fee for service). For details about beneficiaries grandfathered under the CCTP, refer to the *TRICARE Policy Manual*, Chapter 8, Section 15.1 at <http://manuals.tricare.osd.mil>.

## **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Pricing**

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) prices are established by using the Medicare fee schedules, reasonable charges, UnitedHealthcare Fee Schedule, or average wholesale pricing. Most payments of DMEPOS are based on the fee schedule established for each DMEPOS item. The services and/or supplies are coded using CMS HCPCS Level II codes that begin with the letters:

- A (medical and surgical supplies)
- B (enteral and parenteral therapy)
- E (DME)
- K (temporary codes)
- L (orthotics and prosthetic procedures)
- V (vision services)

Inclusion or exclusion of a fee schedule amount for an item or service does not imply TRICARE coverage or non-coverage.

The following modifiers are to be used to identify repair and replacement of an item:

- RA (replacement of an item): The RA modifier on claims denotes instances where an item is furnished as a replacement for the same item that has been lost, stolen, or irreparably damaged.
- RB (replacement of a part of DME furnished as part of a repair): The RB modifier indicates replacement parts of an item furnished as part of the service of repairing the item.

In addition to rates for DMEPOS, enteral and parenteral nutrition items are also included in the DMEPOS fee schedule.

Links to the appropriate Medicare DMEPOS fee schedules may be found on the UnitedHealthcare website at [uhcmilitarywest.com](http://uhcmilitarywest.com) → Reimbursement Rates → Durable Medical Equipment Prosthetics, Orthotics, and Supplies Pricing.

Providers in Colorado, New Mexico, and Texas should refer to PGBA, the Medicare Region C payer, at [www.pgba.com](http://www.pgba.com) for reimbursement information. Providers in Minnesota should refer to National Government Services at [www.ngsmedicare.com](http://www.ngsmedicare.com), and providers in all other states should refer to Noridian Administrative Services, LLC, at [www.noridianmedicare.com](http://www.noridianmedicare.com).

### **Home Infusion Drug Pricing**

Home infusion drugs are those drugs (including chemotherapy drugs) administered in the home by other than oral means (i.e., the drug must be administered either intramuscularly, subcutaneously, intravenously, or infused through a piece of DME). DME verification is not required.

Home infusion drugs must be billed using an appropriate “J” code along with a specific National Drug Code (NDC) for pricing. 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.

### **Assistant Surgeon Services**

TRICARE policy defines an assistant surgeon as any physician, dentist, podiatrist, certified physician assistant (PA), nurse practitioner (NP), or certified nurse midwife acting within the scope of his or her license who actively assists the operating surgeon in the performance of a covered surgical service. 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

All assistant surgeon claims are subject to medical review and need verification that the surgical procedure(s) performed required the services of an assistant surgeon and were medically necessary.

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 a provider bills for a procedure or service performed by a PA, TRICARE policy requires that the supervising or employing physician bill the procedure or service as a separately identified line item (e.g., 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 that 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.

Providers should use the modifier that best describes the assistant surgeon services provided in Box 24D on the *CMS-1500* claim form:

- “Modifier 80” indicates that 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 will most likely pend for medical review to validate the medical necessity for surgical assistance, and medical records may be requested. During this review process, the claim also will be reviewed to validate that this facility has (or does not have) residents and interns on staff (e.g., small community hospital).

## **Hospice Pricing**

The hospice program must enter into an agreement with TRICARE to be eligible for payment. 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

Note: Reimbursement can 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 terminal illnesses. TRICARE will not pay for the room and board charges of the nursing home.

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. One rate will be paid for each level of care, 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.

Note: Continuous home care must be equal to or greater than 8 hours per day, midnight to midnight, with at least 50% of the care provided by licensed practical nursing or registered nursing staff.

The rates will be adjusted for regional differences using appropriate Medicare area wage indexes.

The national payment rates are designed to reimburse the hospice for the costs of all covered services related to the treatment of 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 the locally adjusted national payment rates and not considered hospice services will be for direct patient care services rendered by an independent attending physician.

The hospice will bill for its physician charges/services (physicians under contract with the hospice program) on a *UB-04* using the appropriate revenue code of 657 and the appropriate CPT codes.

Independent attending physician services or patient care services rendered by a physician not under contract with or employed by the hospice are not considered a part of the hospice benefit and are not included in the cap amount calculations. The provider will bill for these services on a *CMS-1500* using the appropriate CPT codes. These services will be subject to standard TRICARE reimbursement and cost-sharing/deductible provisions.

## **Outpatient Prospective Payment System**

TRICARE OPPS was implemented to pay claims for hospital outpatient services.

TRICARE OPPS is mandatory for both network and non-network providers and applies to all hospitals participating in the Medicare program, with some exceptions (e.g., CAHs, cancer hospitals, children's hospitals). TRICARE OPPS also applies to hospital-based partial hospitalization programs (PHPs) subject to TRICARE's prior authorization requirements, and hospitals (or distinct parts thereof) that are excluded from the inpatient DRG-based payment system, to the extent the hospital (or distinct part thereof) furnishes outpatient services.

Several organizations, as defined by TRICARE policy, are exempt from OPPS:

- Critical Access Hospitals (CAH)
- Hospitals located outside the 50 United States, the District of Columbia, and Puerto Rico
- Indian Health Service hospitals that provide outpatient services
- Specialty care providers, including:
  - Cancer and children's hospitals
  - Community mental health centers
  - Comprehensive outpatient rehabilitation facilities
  - Freestanding ambulatory surgery centers (ASC)
  - Freestanding birthing centers
  - Freestanding end-stage renal disease facilities
  - Freestanding PHPs (psychiatric and substance use disorder rehabilitation facilities)
- Home health agencies (HHA)
- Hospice programs
- Other corporate services providers (e.g., freestanding cardiac catheterization and sleep disorder diagnostic centers)
- Residential treatment centers
- Skilled nursing facilities (SNF)
- VA hospitals

OPPS implementation in rural areas for small hospitals with fewer than 100 beds and SCHs began January 1, 2010, when the Medicare transitional corridor payments for these hospitals expired.

For more information on TRICARE OPPS implementation, refer to the *TRICARE Reimbursement Manual*, Chapter 13 at <http://manuals.tricare.osd.mil>. You may also visit [www.tricare.mil/opps](http://www.tricare.mil/opps) or [uhcmilitarywest.com](http://uhcmilitarywest.com).

## Temporary Transitional Payment Adjustments

Temporary Transitional Payment Adjustments (TTPAs) are in place for all hospitals, both network and non-network, to buffer the initial decline in payments upon implementation of TRICARE OPPS. For network hospitals, the TTPAs cover a 4-year period. The 4-year transition sets higher payment percentages for the 10 APC codes for emergency room (ER) and hospital clinic visits (APC codes 604– 609 and 613– 616), with reductions in each transition year.

For non-network hospitals, the TTPAs cover a 3-year period, with reductions in each transition year.

Figure 9.2 shows the TTPA percentages for APC codes 604–609 and 613–616 during the 4-year network hospital and 3-year non-network hospital transition periods.

**TTPA Percentages for APC Codes 604 –609 and 613–616**

**Figure 9.2**

Transition Period	Network <sup>1</sup>		Non-Network <sup>2</sup>	
	ER	Hospital Clinic	ER	Hospital Clinic
May 1, 2009 – April 30, 2010	200%	175%	140%	140%
May 1, 2010 – April 30, 2011	175%	150%	125%	125%
May 1, 2011 – April 30, 2012	150%	130%	110%	110%
May 1, 2012 – April 30, 2013	130%	115%	100%	100%
May 1, 2013 – April 30, 2014	100%	100%	100%	100%

1. The transition period for network hospitals is 4 years. In year 5, TRICARE's payment level will be the same as Medicare's (i.e., 100%).

2. The transition period for non-network hospitals is 3 years. In year 4, TRICARE's payment level will be the same as Medicare's (i.e., 100%).

## Temporary Military Contingency Payment Adjustments

Network hospitals that have received OPPS payments of \$1.5 million or more for care provided to ADSMs and ADFMs during an OPPS year (May 1–April 30) will be given a Temporary Military Contingency Payment Adjustment (TMCPA). Hospitals that qualify for a TMCPA will receive a 20% increase in the total OPPS payments for the initial year of OPPS (May 1, 2009–April 30, 2010). Subsequent adjustments will be reduced by 5% each year until the OPPS payment levels are reached in year 5 (i.e., 15% year 2, 10% year 3, and 5% year 4).

## Updates to TRICARE Rates and Weights

Reimbursement rates and methodologies are subject to change per DoD guidelines. TRICARE rates are subject to change on at least an annual basis. Rate changes are usually effective on the dates listed in Figure 9.3.

**TRICARE Rates Update Schedule**

**Figure 9.3**

Update Frequency	Rates Scheduled to Change
Variable at TMA's discretion	<ul style="list-style-type: none"> <li>• CMAC (may be adjusted quarterly)</li> <li>• Anesthesia</li> </ul>
April 1	<ul style="list-style-type: none"> <li>• Birthing centers</li> </ul>
October 1	<ul style="list-style-type: none"> <li>• DRG</li> <li>• Residential treatment centers</li> <li>• Mental health</li> <li>• SNF PPS (may be adjusted quarterly)</li> <li>• Inpatient hospital copayments and cost-shares</li> <li>• Hospice</li> </ul>
November 1	<ul style="list-style-type: none"> <li>• Ambulatory surgery grouper</li> </ul>
December 1	<ul style="list-style-type: none"> <li>• CAH</li> </ul>

Update Frequency	Rates Scheduled to Change
Quarterly (January, April, July, October)	<ul style="list-style-type: none"> <li>• DMEPOS</li> <li>• Home health PPS</li> <li>• OPSS coding</li> </ul>
Quarterly (February, May, August, November)	<ul style="list-style-type: none"> <li>• Injectables and immunizations</li> </ul>

DoD has adjusted the TRICARE reimbursement rates to mirror Medicare’s levels. Updated rates and weights are available at [www.tricare.mil/tma](http://www.tricare.mil/tma).

Other pricing information is available at [uhcmilitarywest.com](http://uhcmilitarywest.com).

### **No Government Pay Procedure Code List**

The No Government Pay Procedure Code List is a list of codes that are excluded from coverage and are not payable under the TRICARE program. For the most up-to-date No Government Pay Procedure Code List, visit [www.tricare.mil/nogovernmentpay](http://www.tricare.mil/nogovernmentpay).

### **Inpatient-Only List**

For OPSS, non-OPSS, and professional providers, payment will not be made for procedures that are designated as “Inpatient Only.” The list of HCPCS codes on the Inpatient-Only List specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient.

For the most up-to-date Inpatient-Only List, visit [www.tricare.mil/inpatientprocedures](http://www.tricare.mil/inpatientprocedures).

### **Outpatient-Only List**

In an ongoing effort to manage appropriate place of service inpatient and outpatient utilization requests, UnitedHealthcare incorporated a list of common outpatient-only procedures and corresponding codes.

When an inpatient prior authorization request is submitted to UnitedHealthcare, it will be compared to this list. If a match is found to a procedure that normally should be performed in an outpatient setting, it could result in a denial specific to the place of service requested. However, providers will be able to appeal the decision with supporting clinical documentation to support the requested place of service.

Registered users can determine whether a procedure is outpatient or inpatient by researching benefits and checking referral/authorization and medical-review requirements. The “Place of Service” link will display different place of service options and their descriptions in numerical order.



# Provider Tools

## Acronyms

<b>ABA</b>	Applied behavior analysis
<b>ACIP</b>	Advisory Committee on Immunization Practices
<b>ADDP</b>	Active Duty Dental Program
<b>ADFM</b>	Active duty family member
<b>ADSM</b>	Active duty service member
<b>APC</b>	Ambulatory Payment Classification
<b>ASC</b>	Ambulatory surgery center
<b>BHCC</b>	Behavioral Health Contact Center
<b>BMI</b>	Body-mass index
<b>CAC</b>	Common Access Card
<b>CAH</b>	Critical access hospital
<b>CCTP</b>	Custodial Care Transition Program
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CFR</b>	Code of Federal Regulations
<b>CHAMPUS</b>	Civilian Health and Medical Program of the Uniformed Services
<b>CHAMPVA</b>	Civilian Health and Medical Program of the Department of Veterans Affairs
<b>CHCBP</b>	Continued Health Care Benefit Program
<b>CMAC</b>	CHAMPUS maximum allowable charge
<b>CMN</b>	Certificate of medical necessity
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>COB</b>	Coordination of Benefits
<b>CPT</b>	Current Procedural Terminology
<b>CQM</b>	Clinical quality management
<b>CQMP</b>	Clinical Quality Management Program
<b>CTC</b>	Computed tomographic colonography
<b>DBN</b>	DoD Benefits Number
<b>DEERS</b>	Defense Enrollment Eligibility Reporting System
<b>DME</b>	Durable medical equipment
<b>DMEPOS</b>	Durable medical equipment, prosthetics, orthotics, and supplies
<b>DNA</b>	Deoxyribonucleic acid
<b>DO</b>	Doctor of osteopathy
<b>DoD</b>	Department of Defense
<b>DRG</b>	Diagnosis-related group
<b>DSM-IV-TR</b>	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
<b>DTF</b>	Dental treatment facility
<b>E&amp;M</b>	Evaluation and management

<b>ECG</b>	Electrocardiogram
<b>ECHO</b>	Extended Care Health Option
<b>ECT</b>	Electroconvulsive therapy
<b>EDI</b>	Electronic data interchange
<b>EFMP</b>	Exceptional Family Member Program
<b>EFT</b>	Electronic funds transfer
<b>EHHC</b>	ECHO Home Health Care
<b>EIN</b>	Employer identification number
<b>EOB</b>	Explanation of benefits
<b>ER</b>	Emergency room
<b>ERA</b>	Electronic remittance advice
<b>FDA</b>	U.S. Food and Drug Administration
<b>FL</b>	Form Locator
<b>FY</b>	Fiscal year
<b>HbA1c</b>	Hemoglobin A1c
<b>HCPCS</b>	Healthcare Common Procedure Coding System
<b>HEDIS</b>	Healthcare Effectiveness Data and Information Set
<b>HHA</b>	Home health agency
<b>HHS</b>	U.S. Department of Health and Human Services
<b>HIPAA</b>	Health Insurance Portability and Accountability Act of 1996
<b>HITECH</b>	Health Information Technology for Economic and Clinical Health
<b>HNPCC</b>	Hereditary non-polyposis colorectal cancer
<b>HPSA</b>	Health Professional Shortage Areas
<b>HPV</b>	Human papillomavirus
<b>HUAM</b>	Home uterine activity monitoring
<b>ID</b>	Identification
<b>IDME</b>	Indirect medical education
<b>IRS</b>	Internal Revenue Service
<b>IVR</b>	Interactive voice response
<b>LCSW</b>	Licensed clinical social worker
<b>LOD</b>	Line of duty
<b>MCC</b>	Member Choice Center
<b>MD</b>	Medical doctor
<b>MHS</b>	Military Health System
<b>MMSO</b>	Military Medical Support Office
<b>MMWR</b>	Morbidity and Mortality Weekly Report
<b>MRI</b>	Magnetic resonance imaging

<b>MTF</b>	Military treatment facility
<b>NATO</b>	North Atlantic Treaty Organization
<b>NCI</b>	National Cancer Institute
<b>NCQA</b>	National Committee for Quality Assurance
<b>NDC</b>	National Drug Code
<b>NOC</b>	Not otherwise categorized
<b>NP</b>	Nurse practitioner
<b>NPI</b>	National Provider Identifier
<b>NPPES</b>	National Plan and Provider Enumeration System
<b>OHI</b>	Other health insurance
<b>OPPS</b>	Outpatient prospective payment system
<b>P&amp;T</b>	Pharmacy and Therapeutics
<b>PA</b>	Physician assistant
<b>PCM</b>	Primary care manager
<b>PDTS</b>	Pharmacy Data Transaction Service
<b>PHI</b>	Protected health information
<b>PHP</b>	Partial hospitalization program
<b>POA</b>	Present on admission
<b>POS</b>	Point of service
<b>PPS</b>	Prospective payment system
<b>PSA</b>	Prime Service Area
<b>PSPR</b>	Post-service prepayment review
<b>RN</b>	Registered nurse
<b>ROFR</b>	Right of first refusal
<b>RT</b>	Respiratory therapist
<b>RTC</b>	Residential treatment center
<b>RVU</b>	Relative value unit
<b>SCH</b>	Sole community hospital
<b>SHCP</b>	Supplemental Health Care Program
<b>SNF</b>	Skilled nursing facility
<b>SPOC</b>	Service point of contact
<b>SSA</b>	Social Security Administration
<b>SSN</b>	Social Security number
<b>SUDRF</b>	Substance use disorder rehabilitation facility
<b>TAMP</b>	Transitional Assistance Management Program
<b>TCSRC</b>	Transitional Care for Service-Related Conditions
<b>TDP</b>	TRICARE Dental Program
<b>TFL</b>	TRICARE For Life
<b>TIN</b>	Tax Identification Number
<b>TMA</b>	TRICARE Management Activity
<b>TMCPA</b>	Temporary Military Contingency Payment Adjustment
<b>TOP</b>	TRICARE Overseas Program

<b>TPR</b>	TRICARE Prime Remote
<b>TPRADFM</b>	TRICARE Prime Remote for Active Duty Family Members
<b>TQMC</b>	TRICARE Quality Monitoring Contractor
<b>TRDP</b>	TRICARE Retiree Dental Program
<b>TRIAP</b>	TRICARE Assistance Program
<b>TRR</b>	TRICARE Retired Reserve
<b>TRS</b>	TRICARE Reserve Select
<b>TPA</b>	Temporary Transitional Payment Adjustment
<b>TYA</b>	TRICARE Young Adult
<b>UM</b>	Utilization Management
<b>USFHP</b>	US Family Health Plan
<b>VA</b>	U.S. Department of Veterans Affairs
<b>WPS</b>	Wisconsin Physicians Service

## Forms

Samples of the *Health Insurance Claim Form* (CMS-1500) and the *Uniform Bill Form* (UB-04) are illustrated on the following pages.

To download the following forms, visit [uhcmilitarywest.com](http://uhcmilitarywest.com) → Find a Form.

### General

- *An Important Message from TRICARE*
- *An Important Message from TRICARE* (Spanish)
- *Continuous Offset Form*
- *EDI Enrollment Package*
- *Electronic Funds Transfer*
- *Electronic Remittance Advice*
- *Other Health Insurance (OHI) Form*
- *Other Health Insurance (OHI) Form* (Spanish)
- *Third Party Liability Form*
- *UnitedHealthcare Provider EDI Agreement Form*
- *Waiver of Non-Covered Services Form*

### Medical/Surgical Referral/Authorization

- *TRICARE Patient Referral/Authorization Form*
- *TRICARE Patient Referral/Authorization Form* (Sample)

### Behavioral Health

- *Inpatient Admission—PTSD Program*
- *Inpatient Emergency Admission—Detox*
- *Inpatient Emergency Admission—Mental Health*
- *PCM Communication Form*
- *Preauthorization for Electroconvulsive Therapy (ECT)*
- *Preauthorization for Inpatient Substance Abuse Rehabilitation*
- *Preauthorization for Outpatient Treatment Request*
- *Preauthorization for Outpatient Treatment Request* (Sample)
- *Preauthorization for Partial Hospitalization*
- *Preauthorization for Psychological/ Neuropsychological Testing*
- *Residential Treatment Center (RTC) Application*

### Certification

- *Allied Health*
- *Ambulance*
- *Ambulatory Surgical Centers*
- *Autism Services Demonstration Certification*
- *Birth Center*
- *Clinic or Group Practice*
- *Clinical Social Worker*
- *Corporate Services Providers*
- *Durable Medical Equipment and Supply*

- *Home Health Agency*
- *Hospice*
- *Independent Lab*
- *Individual Physician*
- *Institutional Provider*
- *Marriage and Family Therapist*
- *Mental Health Counselor*
- *Nurse—Midwife*
- *Pastoral Counselor*
- *Pharmacy*
- *Physician Assistant*
- *Physiological Laboratories*
- *Psychiatric Hospital*
- *Psychiatric Nurse*
- *Psychologist*
- *Skilled Nursing Facility*

### Clinical Programs

- *Cancer Clinical Trial (CCT) Patient Authorization Form*
- *Case Management Referral Form*
- *ECHO and Autism Patient Referral Form*
- *Hospice Authorization Form*
- *Quality Management (QM) Potential Quality Issue (PQI) Referral*
- *Referral for TRICARE 1:1:1 Program*
- *TBI Program Referral Form*
- *Weight Management Class Consent Form*
- *Weight Management 6-month Follow Up*
- *Weight Management 12-month Follow Up*
- *Weight Management 18-month Follow Up*

### Clinical Information

Injectable Medications:

- *Injectable Medications*
- *Synagis®*
- *Xolair®*

### Medical Equipment/Supplies

- *C-Leg Microprocessor for Lower Limb Prosthesis*
- *Insulin Pump*
- *Wheeled Mobility*

### Therapies

- *Nutritional Therapy*

1500

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA    PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No., Street)
CITY	STATE	CITY
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
10a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	10b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	10c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
10d. RESERVED FOR LOCAL USE	11. INSURED'S POLICY GROUP OR FECA NUMBER	11a. INSURED'S DATE OF BIRTH MM DD YY
11b. EMPLOYER'S NAME OR SCHOOL NAME	11c. INSURANCE PLAN NAME OR PROGRAM NAME	11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____ DATE _____	SIGNED _____	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	20. \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION CODE	22. ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	24. B. PLACE OF SERVICE
24. C. EMG	24. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	24. E. DIAGNOSIS POINTER
24. F. \$ CHARGES	24. G. DAYS OR UNITS	24. H. EPSDT Family Plan
24. I. ID. QUAL.	24. J. RENDERING PROVIDER ID. #	
1		NPI
2		NPI
3		NPI
4		NPI
5		NPI
6		NPI
25. FEDERAL TAX I.D. NUMBER	25. SSN EIN	26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$
30. BALANCE DUE \$	31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER INFO & PH # ( )	a. NPI	b. NPI
SIGNED _____ DATE _____		

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

FOLD HERE / USE ENVELOPE NO. 1500E

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

## Health Insurance Claim Form (CMS-1500) Instructions

Claims must be submitted on the *CMS-1500* 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 CHAMPUS.”
- BOX 1a Sponsor’s Social Security number or Department of Defense 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 Marital and employment status of patient

*Note: Box 11d should be completed prior to determining the need for completing Boxes 9a–9d. If Box 11d is checked “Yes,” Boxes 9a and 9d must be completed. Additionally, if there is another insurance carrier, the mailing address of that insurance carrier must be attached to the claim form.*

- BOX 9 Full name of person with other health insurance (OHI) that covers patient
- BOX 9a Other insured’s policy or group number
- BOX 9b Other insured’s date of birth and sex (*not required, but preferred*)
- BOX 9c Other insured’s employer name or name of school
- BOX 9d Name of insurance plan or program name where individual has 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.*)

*Note: Box 11–Box 11c questions pertain to the sponsor.*

- BOX 11 Indicate policy group or Federal Employees Compensation Act number (*if applicable*).
- BOX 11a Sponsor’s date of birth and sex, if different than Box 3
- BOX 11b Sponsor’s branch of service
- 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 or injury/date of pregnancy (*required for injury or pregnancy*)
- BOX 15 First date patient (*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 Identification (*non-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 (*e.g., laboratory*) performs a service, claims should include modifier "90" or indicate "Yes" in this block.
- BOX 21 Indicate at least 1, and up to 4, specific diagnosis codes.
- BOX 23 Prior 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 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 ID Number
- BOX 26 Patient's account number (*not required, but preferred*)
- BOX 27 Indicate whether provider accepts TRICARE assignment.
- BOX 28 Total charges submitted on claim
- BOX 29 Amount paid by patient or other carrier
- BOX 30 Amount due after other payments are applied (*required if OHI*)
- 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*)



## **CMS-1500 Place of Service Codes**

- 11 Office
- 12 Home
- 15 Mobile unit
- 21 Inpatient hospital
- 22 Outpatient hospital
- 23 Emergency room—hospital
- 24 Ambulatory surgical center
- 25 Birthing center
- 26 Military treatment facility
- 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

1										2										3a PAT. CNTRL #					4 TYPE OF BILL																						
																				b. MED. REC. #																											
																				5 FED. TAX NO.					6 STATEMENT COVERS PERIOD FROM					7 THROUGH																	
8 PATIENT NAME										9 PATIENT ADDRESS																																					
b										c										d					e																						
10 BIRTHDATE			11 SEX		12 DATE			ADMISSION		13 HR		14 TYPE		15 SRC		16 DHR		17 STAT		18		19		20		21		CONDITION CODES		22		23		24		25		26		27		28		29 ACDT STATE		30	
31 OCCURRENCE DATE			32 OCCURRENCE DATE			33 OCCURRENCE DATE			34 OCCURRENCE DATE			35 OCCURRENCE DATE			36 OCCURRENCE DATE			37																													
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42 REV. CD.			43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49																
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23			PAGE ____ OF ____										CREATION DATE										TOTALS																								
50 PAYER NAME										51 HEALTH PLAN ID										52 REL. INFO		53 ASG. BEN.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID																	
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B										C										D		E		F		G		H																			
C										D										E		F		G		H		I																			
58 INSURED'S NAME					59 P. REL.					60 INSURED'S UNIQUE ID					61 GROUP NAME					62 INSURANCE GROUP NO.																											
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63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																											
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**UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
  - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
  - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
  - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
  - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
  - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
  - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
  - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
  - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE <http://www.nubc.org/> FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

## Uniform Bill Form (UB-04) Instructions

The following listing of UB-04 form locators is a summary of the form locator (FL) information.

FL 1	Provider name, physical address and telephone number <b>required</b>
FL 2	Pay-to name and address <b>required</b>
FL 3a	Patient control number
FL 3b	Medical/health record number
FL 4	Type of bill ( <i>3-character alphanumeric identifier</i> )
FL 5	Federal Tax Identification (ID) number
FL 6	Statement covers period ( <i>from– through</i> ). The beginning and ending dates of the period included on the bill are shown in numeric fields ( <i>MM-DD-YY</i> ).
FL 7	Not required
FL 8a-b	Patient's name ( <i>surname first, first name, and middle initial, if any</i> ). Enter the patient's Social Security number (SSN) or Department of Defense Benefits Number (DBN) 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 ( <i>MM-DD-YYYY</i> ). 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 ( <i>diagnoses</i> ) and FL 74 a–e ( <i>surgical procedures</i> ) 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 ( <i>FL 6</i> ).
FLs 18–28	Condition codes
FL 29	Accident state
FL 30	Not required
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 (*e.g., number of days, a particular type of accommodation, pints of blood*). Up to 7 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
- FLs 50A–C Payer identification. Enter the primary payer on line A.
- FLs 51A–C Health plan ID number
- FLs 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 in order to adjudicate the claim. An “R” code indicates the release is limited or restricted. An “N” code indicates no release on file.
- FLs 53A–C Assignment of benefits certification indicator
- FLs 54A–C Prior payments. For all services other than inpatient hospital and skilled nursing facility (SNF) 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.
- FLs 55A–C Not required
- FL 56 National Provider Identifier (NPI). Beginning May 23, 2008, NPI number is required.
- FLs 57A–C Other provider identifier number
- FLs 58A–C Insured’s name
- FLs 59A–C Patient’s relationship to insured
- FLs 60A–C Insured unique ID/SSN/DBN/health insurance claim/ID number
- FLs 61A–C Group name. Indicate the name of the insurance group or plan.
- FLs 62A–C Insurance group number
- FLs 63A–C Treatment authorization code. Contractor-specific or Home Health Agency Prospective Payment System (PPS) OASIS code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient preadmission or preprocedure, the authorization number is required for all approved admissions or services.
- FLs 64A–C Document Control Number (DCN). Original DCN number of the claim to be adjusted.
- FLs 65A–C Employer name. Name of the employer that provides health care coverage for the individual identified on FL 58.
- FLs 66 Diagnosis and procedure code qualifier (*ICD Version Indicator*)

FLs 67	Principal diagnosis code. CMS only accepts ICD-9-CM diagnostic and procedural codes that use definitions contained in Department of Health and Human Services (HHS) Publication Number (PHS) 89-1260 or CMS-approved errata supplements to this publication. Diagnosis codes must be full ICD-9-CM diagnosis codes, including all 5 digits where applicable. For dates of service on or after October 1, 2014, use the relevant ICD-10-CM diagnosis or ICD-10-PCS procedure code. Diagnosis codes must be full ICD-10-CM diagnosis codes, including all 7 digits where applicable.
FLs 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.
FLs 70a–c	Patient’s reason for visit
FL 71	Prospective payment system (PPS) code
FLs 72a–c	External cause of injury (ECI) 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 which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.
FLs 74a–e	Other procedure codes and dates. The full ICD-9-CM, Volume 3, Procedure Codes, including all 4 digits where applicable, must be shown for up to 5 significant procedures other than the principal procedure ( <i>which is shown in FL 74</i> ). The date of each procedure is shown in the date portion of Item 74, as applicable ( <i>MM-DD-YY</i> ). For procedures with dates of service on or after October 1, 2014, the full ICD-10-PCS procedure codes, including all 7 digits, must be shown for up to 5 significant procedures other than the principal procedure.
FL 75	Not required
FL 76	Attending/referring physician ID
FL 77	Operating physician name and identifiers
FLs 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.
FLs 81a–d	Code field



## Condition Codes

- 02 Condition is employment related
- 03 Patient covered by insurance not reflected here
- 06 End-stage renal disease (ESRD) 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 Semiprivate room not available
- 39 Private room medically necessary
- 40 Same-day transfer
- 41 Partial hospitalization
- 46 Nonavailability statement on file
- 48 Psychiatric residential treatment centers for children and adolescents
- 55 SNF 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 SNF 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 ESRD beneficiaries covered by Employer Group Health Plan (EGHP)

### **Value Codes and Amounts**

- 01 Most common semiprivate rate
- 02 Hospital has no semiprivate rooms
- 05 Professional component included in charges and also billed separate to carrier
- 30 Preadmission testing
- 31 Patient liability amount
- 37 Pints of blood furnished
- 46 Number of grace days

## Frequently Used Addresses and Phone Numbers

Resource	Description	Contact Information
<b>United Healthcare Military and Veterans</b>	TRICARE West Region Contractor Effective April 1, 2013.	Phone: (877) 988-WEST(877) 988-9378 Online: uhcmilitarywest.com
<b>Allowable charges</b>	View and download TRICARE-allowable charge rates UnitedHealthcare Fee Schedule	Online: tricare.mil/cmac Online: mytricare.com Online: uhcmilitarywest.com
<b>Authorizations and Referrals</b>	Check referral and prior authorization requests status.	Phone: 877-988-9378 Fax Non-urgent: 877-890-9309 Fax Urgent: 877-890-8203 Fax Hospice: 877-890-8203 Online: uhcmilitarywest.com
<b>Behavioral Health Care</b>	For information about behavioral health benefits, patient eligibility verification, authorizations, and claims	Phone: (877) 988-WEST/(877) 988-9378 Fax: 877-581-1590
<b>Case Management</b>	For UnitedHealthcare Military and Veterans	Phone: 855-874-6800
<b>Case Management (ECHO)</b>	For participants enrolled in the ECHO program.	Phone: 855-874-6800 Fax: 866-269-5758
<b>Case Management (SHCP)</b>	For participants in the Supplemental Health Care Management program	Phone: 888-571-5235
<b>Cancer Clinical Trials Coordinator</b>	For UnitedHealthcare Military and Veterans	Phone: 888-899-4933 Online: cancer.gov
<b>Claims (PGBA)</b>	Contact the West Region claims processor, PGBA, LLC, for assistance.	Inquiries & Status: 877-988-9378 EDI Claims: 800-325-5920 Option 2 Online: mytricare.com
<b>Continued Health Care Benefit Program (CHCBP)</b>	For inquiries, authorizations and referrals and claims inquiries, contact Humana-Military.	Phone: 800-444-5445 Fax: 877-270-9113 Online: mytricare.com
<b>DEERS</b>	Defense Enrollment Eligibility Reporting System (Beneficiaries only)	Phone: 800-538-9552
<b>Dental; Delta Dental</b>	TRDP: For military retirees only	Phone: 888-838-8737 Online: Trdp.org or www.tricare.mil/dental
<b>Dental; Metropolitan Life Insurance Company</b>	TDP: ADFMs, National Guard and Reserve Members, and Individual Ready Reserve.	Phone: 855-638-8371 Online: tricaredentalprogram.com
<b>Dental: United Concordia Companies</b>	ADDP: For Active Duty Service Members (ADSMs) who cannot be seen at an MTF.	Phone: 866-984-ADDP (2337) Online: www.addp-ucci.com www.tricare.mil/dental
<b>ECHO</b>	Information and referrals	Phone: 866-212-0442 Online: Militaryhomefront.dod.mil/efm
<b>Fraud and Abuse</b>	Anonymously report suspected fraud and abuse	Phone: 888-899-5071 Online: www.dodig.mil/hotline/
<b>Inpatient Admission Notifications</b>	Medical/surgical admission and maternity notifications	Fax: 877-578-2738

Resource	Description	Contact Information
<b>KEPRO</b>	To attain TRICARE Certification	Phone: 877-841-6413 Online: Tricare@kepro.com Mail: Attn: TRICARE Operations 777 East Park Drive Harrisburg, PA 17111
<b>Military Medical Support Office (MMSO)</b>	Contact the MMSO for assistance regarding health care for active duty Army, Navy, Air Force, Marine Corps, Coast Guard, and certain TRICARE-eligible National Guard and Reserve members	Phone: 888-MHS-MMSO (888-647-6676) Online: tricare.mil/mmso Mail: Military Medical Support Office P.O. Box 886999 Great Lakes, IL 60088-6999
<b>Provider Information Updates</b>	Contact PGBA for assistance with provider certification and provider information updates.	Phone: 877-988-9378 Fax PGBA: 855-831-7044 Online: mytricare.com
<b>Pharmacy Services: Express Scripts, Inc. (Express Scripts)</b>	Contact the TRICARE Pharmacy Program contractor, Express Scripts, Inc., for assistance with pharmacy benefits, claims, prior authorization, and other services and requirements.	Phone: 877-363-1303 Fax: 877-895-1900 Online: express-scripts.com/tricare Mail: Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072
<b>Member Choice Center (MCC)</b>	To assist beneficiaries with transferring their retail pharmacy prescriptions to home delivery.	Phone: 877-363-1433 Online: www.tricare.mil/pharmacy or www.express-scripts.com/tricare
<b>National Provider Identifier (NPI)</b>	Information and attaining an NPI	Phone: 800-465-3203 Mail: NPI Enumerator P.O. Box 6059 Fargo, ND 58108-6059 Online: nppes.cms.hhs.gov or tricare.mil/tma/hipaa/identifiers
<b>TRICARE For Life (TFL)</b>	Contact the TFL administrator, Wisconsin Physicians Service (WPS)/TFL, for assistance with TFL benefits, claims, and requirements.	Phone: 866-773-0404 TDD: 866-773-0405 Online: TRICARE4U.com Mail: WPS/TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889 (general correspondence only, no claims)
<b>TRICARE North Region</b>	For claims inquiries regarding beneficiaries with a residential address in the North Region contact HealthNet.	Phone: 877-874-2273 Online: Hnfs.com
<b>TRICARE South Region</b>	For claims inquiries regarding beneficiaries with a residential address in the North Region contact Humana-military.	Phone: 800-403-3950 Online: humana-military.com
<b>U.S. Public Health Service (USPHS)</b>	Obtain assistance regarding health care for USPHS personnel.	Phone: 800-368-2777, option 2

## Liability Insurance Requirements Table – TRICARE West Professional

State	UHG Recommended Professional Liability Limits	UHG Minimum Professional Liability Limits	Minimum General Liability Requirements
<b>National Standard in States with No Specified Liability Limits - Low Risk Providers</b>			
Alaska, Arizona, California, Hawaii, Idaho, Iowa, Minnesota, Montana, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington	\$1,000,000 each claim/ \$3,000,000 aggregate	\$500,000 each claim/ \$1,000,000 aggregate	\$1,000,000 per occurrence
<b>UHG Preferred Standard in States with No Specified Liability Limits - High Risk Providers (OB/GYN, Surgeons, Anesthesiologists)</b>			
Alaska, Arizona, California, Hawaii, Idaho, Iowa, Minnesota, Montana, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington	\$5,000,000 each claim/ \$5,000,000 aggregate	\$1,000,000 each claim/ \$3,000,000 aggregate	\$1,000,000 per occurrence
<b>States with Specified Liability Limits</b>			
Colorado	\$1,000,000 each claim/\$3,000,000 aggregate State minimum		\$1,000,000 per occurrence
Missouri	500,000 each claim/aggregate*		\$1,000,000 per occurrence
<b>Patient Compensation Fund States - Mandatory</b>			
Kansas	\$200,000 each claim/\$600,000 aggregate		\$1,000,000 per occurrence
<b>Patient Compensation Fund States - Voluntary</b>			
Nebraska	\$500,000 each claim/\$1,000,000 aggregate		\$1,000,000 per occurrence
New Mexico	\$200,000 per occurrence		\$1,000,000 per occurrence
Wyoming	\$1,000,000 each claim/aggregate		\$1,000,000 per occurrence
<b>Standard Limits Procured in the State</b>			
Texas	\$200,000 each claim/\$600,000 aggregate		\$1,000,000 per occurrence
*Hospital staff located in a county with a population greater than 75,000			

## Liability Insurance Requirements Table – TRICARE West Facilities

State	UHG Recommended Professional Liability Limits	UHG Minimum Professional Liability Limits	Minimum General Liability Requirements
<b>Standard Professional and General Liability Limits</b>			
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	\$1,000,000 each claim/ \$3,000,000 aggregate	\$500,000 each claim/ \$1,000,000 aggregate	\$1,000,000 per occurrence
Texas	\$1,000,000 each claim/ \$3,000,000 aggregate	\$100,000 each claim/ \$300,000 aggregate	\$100,000 per occurrence

## Liability Insurance Requirements Table – TRICARE West Ancillary

State	UHG Recommended Professional Liability Limits	UHG Minimum Professional Liability Limits	Minimum General Liability Requirements
<b>Standard Specified Professional and General Liability Limits</b>			
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	\$1,000,000 each claim/ \$3,000,000 aggregate	\$500,000 each claim/ \$1,000,000 aggregate	\$1,000,000 per occurrence
Texas	\$1,000,000 each claim/ \$3,000,000 aggregate	\$200,000 each claim and aggregate	\$200,000 per occurrence
	\$1,000,000 each claim/ \$3,000,000 aggregate	TX Comprehensive Rehabilitation Program \$500,000 each claim/ \$1,000,000 aggregate	\$1,000,000 per occurrence



