

TRICARE®

North Region Provider Handbook



*Your guide to
TRICARE programs,
policies and procedures*

April 1, 2013 – March 31, 2014



An Important Note about TRICARE Program Information

This *TRICARE North Region Provider Handbook* will assist you in delivering TRICARE benefits and services. At the time of publication, April 1, 2013 – March 31, 2014, the information in this handbook is current. It is important to remember that TRICARE policies and benefits are governed by public law, federal regulation and the Government's amendments to Health Net Federal Services, LLC's (Health Net's) managed care support (MCS) contract. Changes to TRICARE programs are continually made as public law, federal regulation and Health Net's MCS contract are amended. For up-to-date information visit www.hnfs.com or contact Health Net at **1-877-TRICARE (1-877-874-2273)**.

Contracted TRICARE providers are obligated to abide by the rules, procedures, policies and program requirements as specified in this *TRICARE North Region Provider Handbook*, which is a summary of the TRICARE regulations and manual requirements related to the program. TRICARE regulations are available on the TRICARE Management Activity website at www.tricare.mil.

Table of Contents

SECTION 1

Welcome to TRICARE and the North Region

What Is TRICARE?	1
Your Regional Contractor	1
Health Net TRICARE Contract Administration	1
TRICARE Regions	1
Health Net Federal Services Website: www.hnfs.com	2
Provider Relations Outreach Specialists.....	3
Health Net Customer Service Line: 1-877-TRICARE (1-877-874-2273).....	3
<i>TRICARE Provider News</i>	4
TRICARE Service Centers	4
<i>TRICARE North Region Provider Handbook</i> and TRICARE Management Activity Manuals.....	4
Other Provider Resources.....	4
Healthy People 2020: Expand Your Perspective	6
Healthcare Effectiveness Data and Information Set (HEDIS).....	7
Impact Provider™ by OptumInsight™ (formerly Ingenix)	8
National Disaster Medical System (NDMS)	8

SECTION 2

Important Provider Information

TRICARE Policy Resources	9
Health Insurance Portability and Accountability Act of 1996.....	9
TRICARE Provider Types	11
Accepting Patients from the Department of Veterans Affairs	12
Military Treatment Facilities.....	13
TRICARE Pharmacy Home Delivery.....	13
Urgent Care and Convenient Care Clinics.....	14
Emergency Care.....	14
Corporate Services Provider Class	14
Managing the Network.....	15
Provider Certification and Credentialing.....	15
Network Provider Responsibilities	16
Updating Provider Information	21
Beneficiary Rights and Responsibilities	21
ICD-10 Conversion	22
<i>An Important Message from TRICARE</i>	22

SECTION 3

TRICARE Eligibility

Verifying Eligibility	23
TRICARE and Medicare Eligibility.....	24
Eligibility for TRICARE and Veterans Affairs Benefits	25
TRICARE Health Care Program Options	25
TRICARE Prime Coverage Options.....	25

SECTION 3

TRICARE Eligibility continued

TRICARE Prime and TRICARE Prime Remote Primary Care Managers.....	26
TRICARE Prime and TRICARE Prime Remote Point of Service Option.....	26
TRICARE Standard.....	27
TRICARE Young Adult	27
TRICARE For Life	27
TRICARE for the National Guard and Reserve	28
TRICARE Pharmacy Program.....	29
TRICARE Dental Options	33
Cancer Clinical Trials.....	33
TRICARE Extended Care Health Option	34
Supplemental Health Care Program	36
Transitional Health Care Benefits.....	37

SECTION 4

Medical Coverage

Network Utilization	39
Covered Services.....	39
Exclusions.....	66

SECTION 5

Behavioral Health Care Services

Behavioral Health Care Providers	71
Prior Authorization and Referral and Requirements.....	71
Outpatient Services.....	72
Inpatient Services	74
Substance Use Disorder Services.....	76
Telemental Health Program	76
Court-Ordered Care	77
Behavioral Health Care and Other Health Insurance.....	77
Non-Covered Behavioral Health Care Services	77

SECTION 6

Health Care Management and Administration

Advance Directives.....	79
Network Utilization	79
Referral Process.....	79
Prior Authorization Process	81
Submitting Prior Authorization and Referral Requests.....	83
Prioritizing Prior Authorization and Referral Requests and Processing Timelines	84
Prior Authorization and Referral Processing Timelines.....	84
Extending Prior Authorization and Referral Requests from Specialists	85
Appeals of Prior Authorizations.....	85
Providing Care to Beneficiaries from Other Regions and Overseas.....	87
Medical Records Documentation	89

SECTION 6

Health Care Management and Administration continued

Utilization Management.....	91
Clinical Quality Management.....	96
Credentialing and Certification	96
Fraud and Abuse.....	98
Grievances	99

SECTION 7

Claims Processing and Billing Information

North Region Claims Processor.....	101
Claims Processing Standards and Guidelines	101
Important Billing Tips.....	101
Behavioral Health Care Claim Tips	104
Health Insurance Portability and Accountability Act Transaction Standards and Code Sets for Behavioral Health Claims.....	105
Proper Billing for Multiple Procedures.....	105
Medically Unlikely Edit (MUE)	105
Avoid Duplicate Claims.....	105
Electronic Claims Submission	106
XPressClaim Online Claims Processing System	106
Electronic Funds Transfer	107
Claims Submission Addresses	107
Hospital and Facility Billing.....	107
Proper Treatment and Observation Room Billing.....	108
Billing with V Codes	108
How to Bill with V Codes.....	108
Allergy Testing and Treatment Claims.....	109
Eye Exam Claims	109
Global Maternity Claims.....	110
Claims for Mutually Exclusive Procedures.....	110
Physician-Administered Drug and Vaccine Claim Filing	111
Processing Claims for Out-of-Region Care.....	111
Claims for Beneficiaries Assigned to US Family Health Plan Designated Providers	111
TRICARE Overseas/Foreign Claims	112
Claims for Beneficiaries Using Medicare and TRICARE For Life	112
Claims for Foreign Military Beneficiaries.....	113
Claims for Civilian Health and Medical Program of the Department of Veterans Affairs	114
Claims for the Continued Health Care Benefit Program.....	114
Claims for the Extended Care Health Option	114
Claims for TRICARE Reserve Select, TRICARE Retired Reserve and TRICARE Young Adult	115
Supplemental Health Care Program Claims.....	115
TRICARE and Other Health Insurance	116
TRICARE and Third-Party Liability Insurance	117
TRICARE and Workers' Compensation	118
Avoiding Collection Activities	118
TRICARE Claim Disputes	119

SECTION 8

TRICARE Reimbursement Methodologies

Reimbursement Limit.....	121
TRICARE CHAMPUS Maximum Allowable Charge.....	121
TRICARE-Allowable Charge.....	122
Anesthesia Claims and Reimbursement.....	122
Ambulatory Surgery Grouper Rates.....	123
Diagnosis-Related Group Reimbursement.....	124
Present On Admission Indicator.....	124
Diagnosis-Related Group Calculator.....	125
Capital and Direct Medical Education Cost Reimbursement.....	125
Bonus Payments in Health Professional Shortage Areas.....	126
Skilled Nursing Facility Pricing.....	126
Home Health Agency Pricing.....	127
Durable Medical Equipment, Prosthetics, Orthotics and Supplies Pricing.....	127
Home Infusion Drug Pricing.....	128
Modifiers.....	128
Assistant Surgeon Services.....	128
Surgeon's Services for Multiple Surgeries.....	129
Hospice Pricing.....	129
Outpatient Prospective Payment System.....	130
Updates to TRICARE Rates and Weights.....	132

SECTION 9

Provider Tools

Frequently Asked Questions.....	133
Acronyms.....	136
Glossary of Terms.....	138
Forms.....	145
CMS-1500 Place of Service Codes.....	149
North Region Service Codes.....	149
Uniform Bill Form (UB-04) Instructions.....	150
Condition Codes.....	152
Occurrence Span Codes.....	153
Value Codes and Amounts.....	153

Using This *TRICARE North Region Provider Handbook*

This *TRICARE North Region Provider Handbook* has been developed to provide you and your staff with important information about TRICARE emphasizing key operational aspects of the program and program options. This handbook will assist you in coordinating care for TRICARE beneficiaries. It contains information about specific TRICARE programs, policies and procedures. TRICARE program changes and updates may be communicated periodically through the *TRICARE Provider News* and the online publications. The *TRICARE North Region Provider Handbook* is updated annually and as required. You may request a hardcopy version of this handbook through the Health Net website at www.hnfs.com or by calling **1-877-TRICARE (1-877-874-2273)**.

Thank you for your service to America's heroes and their families. If you need any assistance, please contact a TRICARE representative at **1-877-TRICARE (1-877-874-2273)**.

Give Us Your Opinion

We continually strive to improve our materials and value your input as we plan future updates.

If you have any recommended feedback on this handbook contact Health Net at **1-877-TRICARE (1-877-874-2273)**.



Welcome to TRICARE and the North Region



What Is TRICARE?

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

TRICARE brings together military and civilian health care professionals and resources to provide high-quality health care services. TRICARE is managed in three stateside regions – TRICARE North, TRICARE South, and TRICARE West. In these U.S. regions, TRICARE is jointly managed by the TRICARE Management Activity (TMA) and TRICARE Regional Offices. TRICARE Management Activity has partnered with civilian regional 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.

Your Regional Contractor

As the managed care support contractor (MCSC) in the North Region, Health Net Federal Services, LLC (Health Net) administers the TRICARE program in Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Kentucky (except Ft. Campbell area), Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin, and portions of Iowa (Rock Island Arsenal area), and Missouri (St. Louis area).

Health Net TRICARE Contract Administration

Health Net develops and maintains the medical/surgical network, and MHN, a Health Net affiliate company, develops and maintains the behavioral health network. Our partner, PGBA, LLC (PGBA), provides and maintains claims processing and claims customer service.

TRICARE Regions

North Region

Health Net Federal Services, LLC

1-877-TRICARE (1-877-874-2273)

www.hnfs.com

South Region

Humana Military Healthcare Services, Inc.

1-800-444-5445

www.humana-military.com

West Region

UnitedHealthcare Military & Veterans

1-877-988-WEST (1-877-988-WEST)

www.uhcmilitarywest.com



Health Net Federal Services Website: www.hnfs.com

The Health Net Federal Services website, www.hnfs.com, along with PGBA's website, www.myTRICARE.com, provide information about TRICARE benefits, processes, requirements, and operations in the North Region, as well as access to business tools.

Visit the *Provider* section of the www.hnfs.com website to:

- Verify a beneficiary's TRICARE eligibility, other health insurance status, and deductible and catastrophic cap expenses.
- Use the Prior Authorization, Referral and Benefit Tool to learn about prior authorization and referral requirements as well as benefit coverage.
- Access the Primary Care Manager (PCM) Enrollee Roster for a list of beneficiaries enrolled to a PCM.
- Submit and check the status of prior authorization and referral requests.
- Submit and check the status of claims.
- Create claims data reports to view beneficiary claims history, set up electronic funds transfer (EFT) and view remits.
- View the *TRICARE North Region Provider Handbook*, the Quick Reference Charts and *TRICARE Provider News*.
- Refer to errata sheets for changes to the *TRICARE North Region Provider Handbook*.
- Download forms.
- Read important updates about the TRICARE program and Health Net processes.
- Submit secure electronic mail questions using *Ask Us*.

Electronic Funds Transfer

You can sign up for EFT on the [PGBA](http://www.pgba.com) website. Registering for EFT requires having signature authority. This means you are authorized to disburse funds, sign checks, add, modify or terminate bank account information.

Call the toll-free Electronic Data Interchange (EDI) Help Desk at **1-877-EDI-CLAIM (1-877-334-2524)** if you need assistance.

Electronic Claims

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

Benefits of filing claims electronically:

- improved cash flow—on average, TRICARE processes electronic claims two to three weeks faster than paper claims
- reduced postage and paper-handling costs
- elimination of data entry errors

Providers registered on the PGBA website can file claims through **XPressClaim**[®]. XPressClaim allows providers to submit CMS-1500 and UB-04 claims and receive instant payment results for a majority of claims. Providers can also print a patient summary receipt while your patient is still in the office. There is no cost to use XPressClaim. Register for XPressClaim on the [PGBA](http://www.pgba.com) website to begin using it now.

XPressClaim[®] is a registered trademark. All rights reserved.





Online Network Provider Directory

The online [Network Provider Directory](#) makes it easy to locate other TRICARE network providers.

Network Provider Directory information includes:

- location
- provider name
- provider type
- provider specialty
- gender
- accepting new patients status
- office phone number
- office fax number
- additional language(s)

It is important network providers keep demographic information up to date to ensure Health Net provides accurate information to TRICARE beneficiaries and other providers. Network providers are strongly encouraged to visit the online Network Provider Directory to confirm individual listings are accurate.

Network providers can update their information using the Provider Demographic Updates form or through the Network Provider Directory. Within the directory, locate your listing, click on the provider name field, and then click on Suggest Changes to This Provider. If you do not find your listing in the Network Provider Directory, but wish to be listed, contact the Health Net Customer Service Line at **1-877-TRICARE (1-877-874-2273)**.

Most, but not all, network providers are listed in the Network Provider Directory. Emergency room physicians, urgent care physicians and other hospital-based providers **may not** be listed, and non-network providers **are not** listed. Information in the Network Provider Directory is subject to change without notice. Providers should encourage TRICARE beneficiaries to call and confirm a network provider is accepting new TRICARE patients before making appointments.

Provider Relations Outreach Specialists

Provider Relations Outreach Specialists (PROS) are dedicated to making sure the Network Provider Directory has the most up-to-date information, which benefits a provider's practice and patients. Provider Relations Outreach Specialists are assigned to specific locations within the TRICARE North Region.

The PROS confirm:

- name of practice
- physical address
- phone/fax/email
- tax identification number
- pay to address
- National Provider Identifier (NPI)
- any other practice locations and the providers in those locations

Additionally, PROS conduct surveys and serve as educators, offering current information on TRICARE, reimbursement methodologies, claim submission requirements, and fee and payment resolution. Provider Relations Outreach Specialists usually contact providers by telephone and email and offer instructive web-based and onsite sessions to both provider groups and individuals. Providers also may receive fax verification forms as part of the PROS outreach efforts.

Health Net Customer Service Line: 1-877-TRICARE (1-877-874-2273)

Providers can call Health Net's toll-free customer service line, **1-877-TRICARE (1-877-874-2273)**, Monday through Friday, 7:00 a.m. to 7:00 p.m. ET, for general assistance. Additionally, this phone number offers an interactive voice response (IVR) system, giving beneficiaries and providers access to many self-service features 24 hours a day, seven days a week. Follow the prompts to verify beneficiary eligibility, check claims status and review prior authorization and referral requests.



TRICARE Provider News

TRICARE offers network providers the bi-monthly newsletter, *TRICARE Provider News*, which includes articles about important TRICARE benefits and updates, and tips for submitting prior authorization and referral requests and filing claims. To view new and archived issues, visit the Health Net [TRICARE Provider News](#) page.

TRICARE Service Centers

TRICARE Service Centers (TSCs), located throughout the TRICARE North Region, are staffed by customer service representatives who assist beneficiaries and providers. Military treatment facility providers and TSC staff work together to deliver TRICARE health care services and perform administrative actions. To locate a TSC, visit the Health Net [Military Treatment Facility/TRICARE Service Center Locator](#) page.

TRICARE North Region Provider Handbook and TRICARE Management Activity Manuals

This *TRICARE North Region Provider Handbook* is published electronically and provides an overview of TRICARE regulations and requirements contained in the *TRICARE Policy Manual*, *TRICARE Operations Manual* and *TRICARE Reimbursement Manual*. If you need a hard copy of the *TRICARE North Region Provider Handbook* call **1-877-TRICARE (1-877-874-2273)**. To view the [TMA manuals](#) in their entirety and other TRICARE policies visit the [TMA](#) website.

Other Provider Resources

Figure 1.1 provides a list of other provider resources, including resources for claims processing, prior authorizations, referrals, and provider relations.

Provider Resources

Figure 1.1

Resource	Description	Contact Information
Benefits and beneficiary responsibility	TRICARE benefits and beneficiary financial responsibility in the North Region	www.hnfs.com 1-877-TRICARE (1-877-874-2273)
Case Management	Coordinates the beneficiary's health care between the MTFs, providers, and other health care and community resources based on appropriate needs and availability of required services.	Authorizations and Referrals P.O. Box 105423 Atlanta, GA 30348-5423 Fax: 1-877-809-8667
Claims	Claims processing	www.myTRICARE.com 1-877-TRICARE (1-877-874-2273) 1-877-334-2524 (electronic data interchange claims)
CPT® Coding Manual	Request copies or obtain assistance	American Medical Association 515 N. State Street Chicago, IL 60654 1-800-621-8335 www.ama-assn.org
Eligibility	Verify TRICARE beneficiary eligibility through the automated IVR system	www.hnfs.com IVR: 1-877-TRICARE (1-877-874-2273) www.myTRICARE.com

CPT® is a registered trademark of the American Medical Association. All rights reserved.

Copyright 1995 - 2012 American Medical Association. All rights reserved.



Provider Resources continued

Figure 1.1

Resource	Description	Contact Information
Fraud and Abuse	Anonymously report suspected fraud or abuse to Health Net	www.hnfs.com 1-800-977-6761
ICD-9 Diagnosis Coding Manual and HCPCS Manual	Request copies or obtain assistance	OptumInsight™ (formerly Ingenix) 2525 Lake Park Boulevard Salt Lake City, UT 84120 1-800-464-3649, option 1 www.optumcoding.com
Military Medical Support Office (MMSO)	The MMSO supports remotely located active duty, Reservist, and National Guard service members in the Army, Navy, Marine Corps, Air Force and Coast Guard who receive health care through civilian health care systems. The MMSO also provides support to other service member populations such as new recruits en route to their first permanent duty station. The MMSO functions include, but are not limited to, prior authorization of specialty care, dental care and claim payment determinations.	Military Medical Support Office P.O. Box 886999 Great Lakes, IL 60088-6999 1-888-MHS-MMSO (1-888-647-6676) www.tricare.mil/MMSO
Pharmacy services	Pharmacy services, claims, prior authorization, and other services and requirements	Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072 1-877-363-1303 Fax: 1-877-895-1900 www.express-scripts.com/TRICARE
Prior Authorization and Referral Requests	Request prior authorizations and referrals from Health Net	Use the Online Authorization and Referral Submission Tool to request prior authorizations and referrals: www.hnfs.com For urgent requests: 1-877-TRICARE (1-877-874-2273) Outpatient fax: 1-888-299-4181 Inpatient fax: 1-877-809-8667
Prior Authorization and Referral Requirements	Determine if prior authorization or referral from Health Net are required	www.hnfs.com
Prior authorization and referral status check	Check request status	Use the Online Authorization and Referral Status Tool: www.hnfs.com 1-877-TRICARE (1-877-874-2273)



Resource	Description	Contact Information
Credentialing status, demographic and Tax Identification Number (TIN) updates	Check network credentialing status and update demographics and TINs	Credentialing status: 1-877-TRICARE (1-877-874-2273) Online Provider Demographics Update Form
TRICARE rates and reimbursement	View and download TRICARE allowable charge schedules including CHAMPUS Maximum Allowable Charges (CMAC), Diagnosis Related Groups (DRG) rates, etc.	www.tricare.mil
TRICARE For Life (TFL)	Assistance with TFL benefits, claims and requirements	Winconsin Physicians Service/TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889 (<i>general correspondence only, no claims</i>) 1-866-773-0404 1-866-773-0405 (TDD) www.TRICARE4u.com

Healthy People 2020: Expand Your Perspective

What is Healthy People 2020?

TRICARE Management Activity and Health Net support the **Healthy People 2020** goals and encourage provider participation toward this nationwide effort. Healthy People frames the nation’s prevention agenda through 10 years of scientific-based objectives for promoting health and preventing disease. These objectives are based on a collaborative effort among scientific experts in government, private, public and nonprofit organizations that have a common interest in improving the nation’s health. For three decades Healthy People has set and monitored these national health objectives to meet a broad range of health needs, encourage collaborations across many different contributing areas, guide individuals toward making informed health decisions and measure the impact of prevention activities.

Healthy People serves a variety of purposes, ranging from providing information on current health status or public health priority setting, to offering a comprehensive

compilation of statistical information on health promotion and disease prevention. Healthy People is designed to serve as a road map for improving the health of all people in the United States and is a valuable resource in determining how you can participate most effectively in improving the nation’s health.

The vision of Healthy People 2020 is “a society in which all people live long and healthy lives.” The vision, mission and goals offer specific areas of emphasis where action should be taken if the United States is to achieve better health by the year 2020.

Healthy People 2020 strives to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at national, state and local levels.
- Engage multiple sectors to take action to strengthen policies and improve practices that are driven by the best available evidence and knowledge.



- Identify critical research, evaluation and data collection needs.

Healthy People 2020 Goals

Healthy People 2020 has four main goals that apply to all of its objectives:

- attain high-quality, longer lives free of preventable disease, disability, injury, and premature death
- achieve health equity, eliminate disparities and improve health for all groups
- create social and physical environments that promote good health for all
- promote quality of life, healthy development and healthy behaviors across all life stages

What Can You Do?

- Understand the role that prevention, health promotion and community-based health programs have on the determinants of health.
- Integrate Healthy People initiatives into current programs, special events, publications, and meetings.
- Utilize national health observances (for example, National Breast Cancer Awareness Month or American Heart Month) aligned with leading health indicators.
- Monitor community-based and community-determined well-being initiatives to improve “community capacity” and overall wellness.
- Understand your role as a provider, and how you and your patients can benefit from Healthy People goals.
- Encourage patients to pursue healthier lifestyles and to participate in community-based programs.
- Be aware of Healthy People resources, use and refer to them to assist you in developing and implementing programs and interventions for your patients

To stay up to date with the progress of Healthy People 2020 Leading Health Indicators, Goals and Objectives, visit the [Healthy People 2020](#) website.

Healthcare Effectiveness Data and Information Set (HEDIS)

Health Net is committed to quality improvement. To measure quality and improve performance, Health Net utilizes Healthcare Effectiveness Data and Information Set (HEDIS) measures. These measures, developed by the National Committee for Quality Assurance (NCQA), are used by more than 90 percent of America’s health plans to measure performance on many important dimensions of delivery and service.

Health Net monitors and assesses network and physician performance on the following:

- cancer screenings – colorectal, breast and cervical
- diabetes care – annual HbA1c and LDL-C blood tests and retinal eye exams
- asthma medication management
- behavioral health aftercare – seven and thirty-day follow up
- well-child visits

Our aim is to provide the information, resources and support needed to help our providers deliver the best care available to beneficiaries. Each year we strive to make substantial improvements in performance on all measures – something we cannot accomplish without our network





of dedicated providers. For information on coverage for preventive services, see the *Medical Coverage* section of this handbook or to learn more about HEDIS, visit the Health Net [Clinical Quality Initiatives](#) page.

Impact Provider™ by OptumInsight™ (formerly Ingenix)

Impact Provider is an easy-to-use online tool that allows health care providers, registered on the www.hnfs.com website, to access their TRICARE Prime non-active duty service member patients' histories, statuses and compliance with care guidelines.

Using this information helps providers:

- Improve relationships and communications with their patients.
- Enhance quality of services provided.
- Boost performance measurement profiles.

For more information on Impact Provider, visit www.hnfs.com.

National Disaster Medical System (NDMS)

As health care providers, medical/surgical facilities are in the unique position to offer key resources in times of disaster and public health emergencies. Your part as a member of the Disaster Medical Assistance Team (DMAT) – working within the National Disaster

Medical System (NDMS) – providing critical aid in times of natural disasters, major transportation accidents, technological disasters and acts of terrorism, ensures the availability of qualified public health and medical assistance in times of crisis.

You are encouraged to become a member of NDMS. Learn more about this invaluable service by visiting the [NDMS](#) website.

To learn more about the requirements for you or your hospital to become part of a Disaster Medical Assistance Team or to register visit the [Emergency System for Advance Registration of Volunteer Health Professionals](#) website.

TRICARE providers must follow the rules, procedures, policies, and program requirements specified in this *TRICARE North Region Provider Handbook*, and its updates, which summarize TRICARE regulations and requirements related to the program. For more information, visit the [Health Net](#) website or call Health Net at **1-877-TRICARE (1-877-874-2273)**.





Important Provider Information



TRICARE Policy Resources

TRICARE Management Activity (TMA) provides Health Net with guidance – as issued by the Department of Defense (DoD) – for administering TRICARE-related laws. The DoD issues this direction through modifications to the **Code of Federal Regulations** (CFR). The **TRICARE Operations Manual (TOM)**, **TRICARE Reimbursement Manual (TRM)** and **TRICARE Policy Manual (TPM)**, are regularly updated to reflect changes in the CFR. Depending on the complexity of the law and federal funding, it can take a year or longer before the DoD provides direction for administering new policy.

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

Refer to the **TMA Manuals** and **TRICARE Provider News** for current information about policy changes, timelines and implementation guidance.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted on August 21, 1996, to combat waste, fraud and abuse; improve portability of health insurance coverage; and simplify health care administration.

HIPAA 5010

The HIPAA 5010 implementation date was June 30, 2012. The HIPAA 5010 change requires covered entities in the health care industry to implement and use mandated standards in the electronic transmission of health care transactions, such as claims, remittance advices, eligibility confirmations, and claims status requests and responses. Providers should contact their practice management system vendors or clearinghouses to ensure they support the HIPAA 5010 standard.

HIPAA Transactions and Code Sets

The HIPAA Transactions and Code Sets Rule, effective October 16, 2003, implements electronic standards for certain administrative and financial health care transactions. As required by the HIPAA Standard Transactions and Code Sets Rule, the Military Health System (MHS) and TRICARE apply HIPAA standards for electronic business functions. For more information, visit the **HIPAA and TRICARE Transaction & Code Sets** website. Figure 2.1 of this section lists mandated HIPAA electronic transactions. Network providers must utilize electronic data interchange (EDI) per their provider agreement. Non-network providers are encouraged to use EDI functions whenever possible for all transactions containing PHI. Clearly legible and accurate data helps to reduce risk of a privacy incident.

HIPAA Electronic Transactions Figure 2.1

Transaction No.	Transaction Standard
X12N 270/271	Eligibility/Benefit Inquiry and Response
X12N 278	Referral Certification and Authorization
X12N 837	Claims (<i>Institutional, Professional, and Dental</i>) and Coordination of Benefits (COB)
X12N 276/277	Claim Status Request and Response



HIPAA Electronic Transactions

Figure 2.1 continued

X12N 835	Claim Payment and Remittance Advice
X12N 834	Enrollment/Disenrollment in a Health Plan
X12N 820	Payroll Deduction for Insurance Premiums
NCPDP Telecom Std. Ver. 5.1	Retail Pharmacy Drug Claims, COB, Referral Certification and Authorization, Inquiry and Response
NCPDP Batch Std. Ver. 1.1	Retail Pharmacy Drug Claims, COB, Referral Certification and Authorization, Eligibility Inquiry and Response

The Health Insurance Portability and Accountability Act of 1996 requires that all PHI is kept confidential. Appropriate administrative, technical and physical safeguards must be in place to secure PHI. Providers must reasonably safeguard PHI from intentional and unintentional use and disclosure that violates privacy standards, implementation specifications and other requirements. Some state laws are more stringent than HIPAA federal regulations. Providers must comply with both federal and state regulations.

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

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

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

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

HIPAA Employer Identification Number

The National Employer Identifier Final Rule requires health care providers, plans and clearinghouses to accept and transmit employer identification numbers (EINs) in electronic health care transactions, when applicable. The Health Insurance Portability and

HIPAA Privacy Rule

As required by the HIPAA Privacy Rule, provider offices and groups must train all workforce members, as necessary to carry out their functions, on policies and procedures related to protected health information (PHI). Protected health information is information created or received by a provider, health plan or health care clearinghouse and can be in any format (electronic, paper, verbal). It contains information about the past, present or future physical or behavioral health status; provision of health care; or payment for health care that can be linked to a specific individual.

The following are examples of protected health information (this list is not inclusive):

- home address
- home telephone number
- Social Security number
- medical records
- photographs
- any information that may compromise the privacy of or prove harmful to the beneficiary (see **45 CFR sec. 160.103** for PHI definition)



Accountability Act of 1996 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 National Provider Identifier

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

Health care provider NPI enumeration (assignment of NPIs to providers) and NPI-associated data maintenance are conducted through the National Plan 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 two categories of health care providers. A Type 1 NPI is for individuals, such as physicians, nurses, dentists, chiropractors, pharmacists, and physical therapists. A Type 2 NPI is for organizations, such as hospitals, home health agencies, clinics, nursing homes, laboratories, and military treatment facilities (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 or download a paper application of the National Provider Identifier (NPI) Application/Update Form. You can also request an application from the NPI Enumerator in one of the following ways:

Phone	1-800-465-3203 1-800-692-2326 (TTY)
Email	customerservice@npienumerator.com
Mail	NPI Enumerator P.O. Box 6059 Fargo, ND 58108-6059

Providers registered with **PGBA's** website can submit NPIs to Health Net online. For those providers without Internet access, network providers can fax their NPI information to **1-888-244-4025** and for non-network providers, fax to **1-888-250-4355**. For more information about NPIs, visit the Centers for Medicare and Medicaid Services (CMS) website. For TRICARE-specific information, visit the **TMA** website.

Military Health System Notice of Privacy Practices

The Military Health System Notice of Privacy Practices informs beneficiaries about their rights regarding PHI, and it explains how PHI may be used or disclosed, who can access it and how it is protected. The Notice is published in 11 languages. Braille and audio versions are also available. Visit **TMA's** website to download copies of the Military Health System Notice of Privacy Practices for you and your staff.

Privacy officers are located at every military treatment facility (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 on **TMA's** website. Beneficiaries and providers also may email inquiries to **privacymail@tma.osd.mil**.

Certificate of Creditable Coverage

In compliance with HIPAA portability requirements, the MHS, through the Defense Manpower Data Center Support Office (DMDC), automatically issues certificates of creditable coverage to beneficiaries who lose TRICARE coverage. For additional information, visit the **TMA** website.

TRICARE Provider Types

TRICARE provider types include physicians, physician organizations, other health care professionals or facilities that provide health care. For example, doctors and other health care professionals, hospitals and ambulance companies are providers. Providers must be authorized under TRICARE regulations, and Health Net must certify providers to deliver health care to TRICARE North Region beneficiaries.



Note: Federal government employees – including active duty service members (ADSMs) – who are health care providers are generally not TRICARE-authorized to provide care in civilian facilities. TRICARE only reimburses TRICARE-authorized providers. Figure 2.2 provides an overview of various TRICARE provider types.

TRICARE Provider Types

Figure 2.2

TRICARE-Authorized Civilian Providers		
<ul style="list-style-type: none"> • TRICARE-authorized civilian providers meet TRICARE licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (laboratories and radiology providers) and pharmacies. TRICARE-authorized providers do not include pharmacists, naturopaths, chiropractors, kinesiologists, massage therapists, genetic counselors, or any other provider type not specifically named in <i>TRICARE Policy Manual, Ch. 11</i>. Please refer to <i>TRICARE Policy Manual, Ch. 11</i> for TRICARE-authorized provider requirements. Beneficiaries are responsible for the full cost of care if they see providers who are not TRICARE authorized. • There are two types of TRICARE-authorized providers: Network and Non-Network. 		
Network Providers ¹	Non-Network Providers	
<ul style="list-style-type: none"> • Regional contractors (for example, Health Net) have established networks, even in areas far from MTFs TRICARE network providers: <ul style="list-style-type: none"> • Have signed agreements with Health Net and/or MHN to provide care. • Agree to file claims and handle other paperwork for TRICARE beneficiaries. 	<ul style="list-style-type: none"> • Non-network providers do not have signed agreements with Health Net and are, therefore, considered “out of network.” Beneficiaries must have approval from Health Net to seek care from non-network providers. • There are two types of non-network providers: participating and nonparticipating. • Providers may choose to participate on a case-by-case basis. 	
	Participating	Nonparticipating
	<ul style="list-style-type: none"> • May choose to participate on a claim-by-claim basis • Agree to file claims for TRICARE beneficiaries, accept payment directly from TRICARE and accept the TRICARE allowable charge as payment in full for their services 	<ul style="list-style-type: none"> • Do not agree to accept the TRICARE allowable charge or file claims for TRICARE beneficiaries • Have the legal right to charge beneficiaries up to 15% above the TRICARE allowable charge for services*

¹ Network providers must have malpractice insurance.

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

Note: TRICARE network providers have agreed to accept the TRICARE allowable charge as payment in full for their services.

Accepting Patients from the Department of Veterans Affairs

The Veterans Affairs (VA) and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) are not TRICARE programs. They are unique health care benefit programs administered by the VA.

Veterans Affairs Patients

Non-institutional network providers are asked to accept requests from the VA to provide care to Veterans and eligible family members. The VA has the right to directly contact providers and request that they provide care specifically to Veterans on a case-by-case basis. If a provider agrees to see a VA patient, the referral and instructions for seeking reimbursement from the VA Medical Center (VAMC) will be provided by the patient at the time of the appointment. However, if the VA patient is also a TRICARE beneficiary, TRICARE procedures should be followed.



All VA facilities in the North Region are TRICARE providers and must function as any other TRICARE provider. If a VA facility cannot see a TRICARE beneficiary, the VA provider must refer the beneficiary to a TRICARE network provider.

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

All TRICARE network providers are listed in the [Network Provider Directory](#) as willing to receive VA patients based on availability. If you are a network provider and choose not to accept VA patients, you can update your information using the [Provider Demographic Updates](#) form or through the [Network Provider Directory](#).

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

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

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

Health Net reports network providers to CHAMPVA as TRICARE network providers. Health Net requires TRICARE network providers (individual, home health care, freestanding laboratories and freestanding radiology only) who accept CHAMPVA patients to accept assignment with the VA. These providers are listed in the [Network Provider Directory](#) as accepting CHAMPVA patients and accepting assignments on claims. If you are a network provider and choose not to accept CHAMPVA patients, you can update their information using the [Provider Demographic Updates](#) form or through the [Network Provider Directory](#).

Instructions on how to submit CHAMPVA claims ([CHAMPVA Fact Sheet 01-16](#)) are available on the [Health Net](#) website. Also see the *Claims Processing and*

Billing Information section of this handbook for more information about submitting CHAMPVA claims.

Military Treatment Facilities

A military treatment facility (MTF) is a military hospital or clinic usually located on or near a military installation. The TRICARE civilian provider network supplements MTF resources and may work closely with MTFs so that patients get the care they need. Military treatment facilities are also listed in the [Network Provider Directory](#).

Military Treatment Facility Right of First Refusal

A military treatment facility (MTF) has the right of first refusal (ROFR) concerning TRICARE Prime referrals for inpatient admissions, specialty appointments and procedures requiring prior authorization or referral. This means TRICARE Prime beneficiaries must first try to obtain care at MTFs. Military treatment facility staff members review referrals to determine if they can provide care within [access standards](#). If the service is not available within access standards, the beneficiary will be referred to a TRICARE civilian network provider.

Note: The ROFR process does not apply to ADSMs or active duty family members (ADFM) enrolled in TRICARE Prime Remote seeking care at an MTF.

TRICARE Pharmacy Home Delivery

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

New prescriptions can be faxed (with a fax cover sheet) directly to Express Scripts at **1-877-895-1900**. Faxed prescriptions must contain the following information in order to be processed: patient's full name, date of birth, address, and sponsor's Social Security number or [Department of Defense \(DoD\) Benefits Number \(DBN\)](#). Only prescriptions faxed directly from a provider's office will be accepted. Prescriptions for Schedule II controlled



substances cannot be faxed (they must be mailed). Visit the [Express Scripts](#) website or call Express Scripts at **1-877-363-1303** for more information.

Express Scripts[®], Inc. is a registered trademark. All rights reserved.

Urgent Care and Convenient Care Clinics

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

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

If you are not available to provide a same-day appointment, you may refer the beneficiary to an **urgent care center or convenient care clinic**. For TRICARE Prime beneficiaries, urgent care at an urgent care center or a convenient care clinic must be coordinated with their PCM and approved by Health Net, otherwise the care might be paid under the **point of service (POS) option**. If beneficiaries are away from home or need care after hours and cannot wait to see their PCM, they must contact their PCM for a referral, or call Health Net for assistance before receiving urgent care.

Emergency Care

TRICARE defines an emergency as a medical, maternity or behavioral health condition that would lead a layperson to believe that a serious medical condition exists. This includes situations when the absence of immediate medical attention would result in a threat to life, limb or sight; when a person has severe, painful symptoms that require immediate attention to relieve suffering; or when a person is an immediate risk to self or others.

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

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

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

Corporate Services Provider Class

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

- cardiac catheterization clinics
- comprehensive outpatient rehabilitation facilities
- diabetic self-management education programs (American Diabetes Association accreditation required)
- freestanding bone marrow transplant centers
- freestanding kidney dialysis centers
- freestanding magnetic resonance imaging centers
- freestanding sleep disorder diagnostic centers
- home health agencies (pediatric or maternity management required)
- home infusion
- independent physiological laboratories
- 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 can download the application for TRICARE Provider Status/Corporate Services Provider at [PGBA's](#) website or call Health Net at **1-877-TRICARE (1-877-874-2273)** for assistance.

Note: Claims must identify the provider who actually renders care and the location where services were delivered.

Corporate services providers who deliver home health care are exempt from prospective payment system billing rules. For more information about corporate services provider coverage and reimbursement, refer to the [TRICARE Policy Manual, Ch. 11, Sec. 12.1](#).



Managing the Network

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

Provider Certification and Credentialing

TRICARE Certification – Becoming a Non-Network Provider

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

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

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

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

In many cases, providers can see TRICARE patients and file claims with TRICARE to initiate the certification process. However, some behavioral health care providers, certain non-Medicare-certified providers, skilled nursing facilities and others must submit certification forms to PGBA, LLC prior to providing

health care services. Download certification forms at www.hnfs.com/go/TRICAREdocs.

Behavioral Health Care Providers

Freestanding partial hospitalization programs (PHPs), residential treatment centers (RTCs) and substance use disorder rehabilitation facilities (SUDRFs) must first be certified by Keystone Peer Review Organization, Inc. (KePRO®), the TRICARE Quality Monitoring Contractor. Providers should visit the KePRO website www.kepro.org for more information. Once KePRO certifies the facility, the provider must complete the MHN contracting process if the facility wants to become a network provider. Visit the **MHN** website or call **1-800-541-3353** for more information.

For TRICARE certification:

- **Acute care hospital-based PHPs** – Must be certified by The Joint Commission only.
- **Freestanding PHPs** – Must be certified by KePRO and enter into a participation agreement with TRICARE and obtain required authorization prior to admitting patients. Freestanding PHPs interested in becoming TRICARE authorized should contact **KePRO**.

KePRO™ is a registered trademark. All rights reserved.

TRICARE Credentialing – Becoming a Network Provider

To join the TRICARE network, a TRICARE-authorized provider must complete the credentialing process and sign an agreement with Health Net. The credentialing process requires verification of the provider’s education, board certification, license, professional background, malpractice history, and other pertinent data. A fully executed copy of the agreement will be forwarded to the provider. Health Net monitors each network provider’s quality of care and adherence to DoD, TRICARE and Health Net policies. Network providers must be re-credentialled every three years.

Note: Behavioral health care providers – including freestanding PHPs, RTCs and SUDRFs – must be credentialed by MHN. For more information, visit the **MHN** website or call MHN at **1-800-541-3353**.

For more information about TRICARE certification and credentialing, visit our **How Do I Become a TRICARE Provider?** page on Health Net’s website and see the



Health Care Management and Administration section of this handbook.

Network Provider Responsibilities

Network providers sign agreements with Health Net and/or MHN to comply with all TRICARE and Health Net regulations. **This handbook is not all-inclusive** and only provides an overview of TRICARE policies and procedures. Providers must have and maintain a current legal/agreement notice and general education fax number, a HIPAA-compliant prior authorization and referral fax number and a legal/agreement notice and general education email address. To update the legal/agreement notice and general education email address or fax number, providers must submit a letter addressed to Provider Network Management, and fax to **1-888-244-4025**. For more information about provider responsibilities and agreement requirements, visit the [Health Net](#) website or call Health Net at **1-877-TRICARE (1-877-874-2273)**.

Providers must relay any changes to demographic information to Health Net using either the [Provider Demographic Updates form](#) or through the online [Network Provider Directory](#). You may also fax updated information to **1-888-244-4025**.

Non-Discrimination Policy

All TRICARE-authorized providers agree not to discriminate against any TRICARE beneficiary on the basis of his or her participation in TRICARE, source of payment, sex, age, race, color, religion, national origin, health status, or disability. To access the full TRICARE policy, refer to the [TRICARE Operations Manual, Ch. 1, Sec. 5](#).

Office and Appointment Access Standards

TRICARE access standards ensure beneficiaries receive timely care within a reasonable distance from their homes. Emergency services must be available 24 hours a day, seven days a week.

Network and MTF providers must adhere to the following access standards for non-emergency care:

- urgent care or acute illness appointment – 24 hours
- routine care appointment – one week (seven calendar days) and within 30 minutes travel time of the beneficiary's residence

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

- specialty care appointment – four weeks (28 calendar days) and within one hour travel time from the beneficiary's residence
- preventive care appointment – four weeks (28 calendar days)
- initial behavioral health care appointment with a behavioral health care provider – one week (seven calendar days)

Office wait times for non-emergency care appointments should not exceed 30 minutes except when the provider's normal appointment schedule is interrupted due to an emergency. If running behind schedule, notify the patient of the cause and anticipated length of the delay and offer to reschedule the appointment. The patient may choose to keep the scheduled appointment or reschedule for a future date or time.

Cancelled or Missed Appointments

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

Primary Care Manager's Role

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

- certified nurse midwives
- family practitioners
- general practitioners
- internal medicine physicians
- nurse practitioners



- obstetricians/gynecologists
- pediatricians
- physician assistants

Each TRICARE Prime and TPR beneficiary selects or is assigned a PCM when he or she enrolls. Whenever possible, an MTF PCM is assigned. Otherwise, a TRICARE network civilian PCM is assigned or a non-network provider for TPR beneficiaries.

A TRICARE Prime or TPR beneficiary requires a prior authorization and/or referral to seek care from any provider other than his or her PCM, except in the following circumstances:

- if using the **point of service (POS) option**, which allows a TRICARE Prime/TPR beneficiary (non-active duty service member) to receive non-emergency care without a referral from his or her PCM; however, when using this option, the beneficiary must pay a higher cost-share and a deductible
- in an emergency
- if seeking preventive services from a network provider
- for the first eight outpatient behavioral health care therapy visits to a network provider per fiscal year (FY) (October 1–September 30)

Note: Active duty service members (ADSMs) need prior authorization and/or referral for all non-emergency civilian care, including all behavioral health care services.

The PCM's responsibilities include:

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

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

- determining the level of care needed:
 - urgent care – instructing the patient to contact the PCM's office on the next business day to schedule an appointment
 - routine care – coordinating timely care for the patient
- referring patients for specialty care and obtaining prior authorizations and referrals, when required, from Health Net

Note: It is the provider's responsibility to verify and update demographic information, panel status, and the ability to meet appointment and access standards. Providers can change information through the **Network Provider Directory**, the **Provider Demographics Updates** form, or notify Health Net in writing 10 days in advance of any demographic information changes. Also, you may fax information to **1-888-244-4025**.

Specialty Care Responsibilities

TRICARE Prime and TPR beneficiaries require a referral from their PCM for specialty care and may also require a referral from Health Net. The PCM and specialty care provider should coordinate with Health Net to obtain prior authorizations and referrals. Network and non-network providers must follow TRICARE procedures and requirements for services that require prior authorization or referral. Per **TRICARE Reimbursement Manual, Ch. 1, Sec. 28**, network and non-network providers, who submit claims for services without obtaining a prior authorization when required, will receive a 10 percent payment reduction during claims processing. For a network provider, the penalty may be greater than 10 percent depending on whether his or her network contract includes a higher penalty. Those payment penalties cannot be passed onto the beneficiary for payment. It is the provider's responsibility to obtain prior authorization when required. Use the **Prior Authorization, Referral and Benefit Tool** to determine if a prior authorization or referral is needed.

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

TRICARE Prime:

- Active duty service member: PCM and Health Net referrals are required for all civilian specialty care. Additionally, prior authorization from Health Net is required for most services.



- Active duty family members: PCMs should refer patients to MTFs or network providers whenever possible. Active duty family members must obtain a PCM and Health Net referral for most care they receive from providers other than their PCMs or an on-call physician acting on behalf of their PCMs. This excludes preventive care services from network providers, the first eight outpatient behavioral health care therapy visits from network providers per FY (Oct 1–Sept 30) or when using the **POS option**. Additionally, prior authorization from Health Net is required for certain services.

TRICARE Standard:

- Beneficiaries may self-refer to TRICARE-authorized specialty care providers; however, prior authorization from Health Net is required for certain services. Use the **Prior Authorization, Referral and Benefit Tool** to determine prior authorization requirements.

Note: Providers should use the **Online Authorization and Referral Submission Tool** to request prior authorizations and referrals. Online requests are preferred; however, Health Net will accept requests using either the **Outpatient or Inpatient TRICARE Service Request/Notification Form** via fax (outpatient: **1-888-299-4181** or inpatient: **1-877-809-8667**) if the provider is unable to submit electronically.

Clearly Legible Reports

Network providers must provide clearly legible reports (CLRs), which include specialty care consultation/referral reports, operative reports, notes on the episode of care and discharge summaries to the MTF within seven business days of care delivery. Behavioral health care network providers must submit brief initial assessments within seven business days. The requirement to submit CLRs applies to care referred from an MTF and assists the MTF in meeting The Joint Commission requirements. The reports should contain a patient's identifying information such as first name, middle initial, last name, date of birth, and the last four digits of the sponsor's SSN.

Upon receipt of an approved prior authorization or referral from Health Net, providers will receive a letter that contains a local secure MTF fax number for submitting the CLR with the MTF. Network providers must follow the instructions included with the prior authorization and/or referral from Health Net.

Health Net requires network providers to fax all CLRs directly to the secure fax number for the requesting MTF. The **CLR Fax Matrix**, found on the **Clearly Legible Reports** page on the Health Net website, lists each MTF's secure fax number for providers to use. The CLR Fax Matrix also lists contact information should you have any CLR questions.

Note: The CLR secure fax number **should not** be used to fax Inpatient or Outpatient TRICARE Service Request/Notification forms for prior authorization and referral requests.

For care referred by a non-MTF (civilian) provider, reports should **not** be sent to the MTF secure fax number. Follow your normal office protocol and forward non-MTF referred consultation reports to the requesting provider within seven business days of the service or sooner if clinically appropriate. Submission of CLRs to civilian providers is important as it ensures all treating providers are updated on the beneficiary's care.

Urgent and Emergency Care CLR Responsibilities

In urgent and emergency situations, a preliminary report of a specialty consultation should be provided to the referring provider or MTF by telephone or using the MTF's secure fax number within 24 hours of the urgent/emergency care (unless best medical practices dictate less time is required for a preliminary report). Telephonic reports should be followed up with a CLR within seven business days of the urgent/emergent care. MTF individual fax numbers can be found in the **CLR Fax Matrix**, found on the **Clearly Legible Reports** page.

Emergency Care Responsibilities

TRICARE providers must notify Health Net of an emergency room inpatient admission within 24 hours, or by the next business day, by faxing the patient's hospital admission record face sheet to Health Net at **1-877-809-8667**. The hospital admission record face sheet should include the beneficiary's demographic information, health plan information, name of the admitting physician and admitting diagnosis and date. If the hospital admission record face sheet is not available, providers can also complete an **Inpatient TRICARE Service Request/Notification form** and fax it to **1-877-809-8667**. Be sure to note on the form that the information is for an emergency inpatient admission notification.



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

Balance Billing

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

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

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

TRICARE uses Medicare's billing limitations. Non-compliance with balance billing requirements may affect a provider's TRICARE and/or Medicare status. Balance billing limitations only apply to TRICARE-covered services. Providers may not bill beneficiaries for administrative expenses, including collection fees, to collect TRICARE payment. Additionally, network providers cannot bill beneficiaries for non-covered services unless the beneficiary agrees in advance and in writing to pay for these services. See "Informing Beneficiaries about Non-Covered Services" and "Hold Harmless Policy" later in this section for more information.

For more information about balance billing, visit the Health Net [Balance Billing](#) page or call Health Net at **1-877-TRICARE (1-877-874-2273)**.

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

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

It is imperative network providers use the [Request for Non-Covered Services form](#) available on Health Net's website or equivalent (such as a statement or letter written, dated and signed by the beneficiary prior to receipt of services) to satisfy these requirements. A general agreement to pay, such as one signed by the beneficiary at the time of admission, is not sufficient to prove that a beneficiary was properly informed or agreed to pay. Notes demonstrating that the beneficiary has been fully informed in advance of receiving the services, that the services are excluded or excludable and that the beneficiary has agreed to pay for them must be documented in writing in the patient's file. If the beneficiary does not sign a [Request for Non-Covered Services form](#) or equivalent, the provider is financially responsible for the cost of non-covered services he or she delivers. Network providers should keep copies of the [Request for Non-Covered Services form](#) or equivalent 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 Network Providers

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

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



Providers should be aware that there have been incidents when a TRICARE beneficiary has agreed to pay in full for non-covered services without signing a valid waiver. The provider rendered the care in good faith without prior authorization, and the beneficiary was not held responsible for payment. Without a signed waiver, the provider was denied reimbursement and could not bill the beneficiary. To find out more about TRICARE's Hold Harmless Policy, please refer to the **TRICARE Operations Manual, Ch. 5, Sec. 1.**

Hold Harmless Policy for Non-Network Providers

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

Release of Patient Information

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

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

Per the *TRICARE Operations Manual, Ch. 7, Sec. 1*, Health Net cannot disclose information about the following services to parents or guardians of any beneficiaries, including minors and mentally or physically disabled beneficiaries:

- AIDS
- alcoholism
- abortion
- substance abuse
- venereal disease

TRICARE-eligible beneficiaries must maintain a "signature on file" in their physicians' office to protect patient privacy, release important information and prevent fraud. A new signature is required for each admission for claims submitted on a UB-04 claim form, but only once each year for professional claims submitted on a Health Insurance Claim Form (CMS-1500). Claims for diagnostic tests, test interpretations

and certain other services do not require the beneficiary's signature. Providers submitting these claims must indicate "patient not present" on the claim form.

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

- If the beneficiary does not have legal representation, the provider must submit a written report with the claim to describe the patient's illness or degree of mental disability and should annotate in Box 12 of the CMS-1500 claim form, "Patient's or Authorized Person's Signature—Unable to Sign."
- If the beneficiary's illness was temporary, the signature waiver must specify the dates the illness began and ended.
- If a beneficiary is mentally competent but physically incapable of providing a signature, a representative may be issued a general or limited power of attorney by signing an "X" in the presence of a notary representative.

Release of Medical Records

Health Net representatives must comply with the HIPAA Privacy Rules when TRICARE beneficiaries or their personal representatives call regarding claims and other patient-specific information. If information is requested on behalf of someone else, Health Net cannot disclose information until a HIPAA-compliant **Authorization for Disclosure of Medical or Dental Information** form or the appropriate legal paperwork is received (for example, powers of attorney, guardianship, divorce/custody agreements, etc). Without the appropriate documents, Health Net will not disclose information to a beneficiary who:

- calls on behalf of a spouse or adult child, age 18 or older (age 21 or older in Pennsylvania)
- is the guardian (other than mother or father) of a minor child
- is the spouse of a deployed ADSM
- is divorced from the child's TRICARE sponsor



- was never married to his or her child's TRICARE sponsor
- has a different last name than the eligible child and/or multiple spouses are listed on the account (for example, eligible stepchildren of the sponsor)
- is the spouse or family member of a deceased sponsor

If you have additional questions about the HIPAA Privacy Rule and TRICARE, call Health Net at **1-877-TRICARE (1-877-874-2273)** or visit the **TMA** and **U.S. Department of Health and Human Services** websites.

Dismissing A TRICARE Beneficiary from Your Care

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

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

Updating Provider Information

The Health Net website, www.hnfs.com, includes a provider directory to help beneficiaries and other providers find TRICARE network providers. Keeping your information up to date ensures that Health Net sends payments to your correct address and that TRICARE beneficiaries and other providers have your current contact information. In addition, keeping your information current helps everyone avoid inadvertent disclosures of patients' protected health information.

Network providers are requested to visit the online **Network Provider Directory** to confirm that their individual listings and statuses are accurate. If you are not listed in the Network Provider Directory and wish to, contact the Health Net Customer Service Line at **1-877-TRICARE (1-877-874-2273)** to inquire about being listed.

Providers may update their information using the **Provider Demographic Updates Form** or through the **Network Provider Directory**. For those providers who cannot update their information electronically, fax updated demographic information to **1-888-244-4025**.

The Network Provider Directory does not include non-network providers. However, non-network providers are encouraged to verify or update contact information, or fax updated information to **1-888-250-4355** or **1-888-279-3540**.

Beneficiary Rights and Responsibilities

TRICARE Beneficiaries Have the Right to:

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

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

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

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

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

Confidentiality of health information – Beneficiaries have the right to communicate with health care providers in confidence and to have the confidentiality of their health care information protected as required by law. They also have the right to review, copy and request amendments to their medical records.

Complaints and appeals – Beneficiaries have the right to a fair and efficient process for resolving differences



with their health plans, health care providers and the institutions that serve them.

For more information about beneficiary rights, visit the [TMA](#) website.

TRICARE Beneficiaries Have the Responsibility to:

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

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

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

TRICARE beneficiaries also have the responsibility to:

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

Active duty family members enrolled in TRICARE Prime or TRICARE Prime Remote do not have copayments, cost-shares or deductibles, except for:

- pharmacy copayments
- **point of service option** cost-shares and deductibles
- TRICARE ECHO cost-shares

TRICARE beneficiaries cannot be billed for the following charges:

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

ICD-10 Conversion

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. To accommodate the ICD-10 code structure, the transaction standards used for electronic health care claims, Version 4010/4010A, had to be upgraded to Version 5010 as of June 30, 2012.

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA).

Visit the [Centers for Medicare and Medicaid Services](#) website for more ICD-10 information or the Health Net [ICD-10 Implementation](#) page.

An Important Message from TRICARE

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



TRICARE Eligibility



TRICARE is available worldwide to eligible beneficiaries, including active duty service members (ADSMs) and their families, retired service members and their families, National Guard and Reserve members and their families, survivors, certain former spouses and others, from any of the seven uniformed services – 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. All beneficiaries must register in the Defense Enrollment Eligibility Reporting System (DEERS) to be eligible for TRICARE. Beneficiaries can verify their eligibility in DEERS by calling **1-800-538-9552**. However, providers must check beneficiary eligibility online through **Health Net's** website or through the Health Net Federal Services, LLC (Health Net) interactive voice response (IVR) system at **1-877-TRICARE (1-877-874-2273)**.

Verifying Eligibility

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

Note: The TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Reserve Select (TRS), and TRICARE Retired Reserve (TRR) enrollment cards do not guarantee eligibility to obtain care but do contain important information for beneficiaries.

A CAC or ID card alone does not prove TRICARE eligibility. All eligibility is based on the Defense Enrollment Eligibility Reporting System (DEERS). Beneficiaries can verify their eligibility in DEERS by calling **1-800-538-9552**. Providers must verify the beneficiary's TRICARE eligibility online through **Health Net's website** or through the IVR system at

1-877-TRICARE (1-877-874-2273). Use the sponsor's Social Security number (SSN) to verify eligibility. If you are verifying online, retain a printout of the eligibility verification screen for your files.

Common Access Card

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

Uniformed Services Identification Card

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

Identification cards include the following information:

- **Expiration date** – Check the expiration date (should read "INDEF" for retirees). If expired, the beneficiary must immediately update his or her information in DEERS and get a new card.
- **Civilian** – Check the back of the ID card to verify eligibility for TRICARE civilian care. The center section should read "YES" under the box titled "Civilian." A TRICARE For Life (TFL) beneficiary with an ID card that reads "NO" in this block may still use TFL only if he or she has both Medicare Part A and Part B coverage.



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

Newborns and adopted children must be registered in **DEERS** within 365 days of birth or adoption or DEERS will show "loss of eligibility." After this time period, newborns and adopted children will no longer be able to receive TRICARE benefits until registered in DEERS. **Some TRICARE programs require enrollment. This is separate from registration in DEERS.** For information on verifying eligibility for newborns, visit [Health Net's website](#).

Social Security Number Reduction Plan — DoD Benefits Number

To protect personally identifiable information, the Department of Defense (DoD) is removing Social Security numbers (SSNs) from all DoD ID cards. This SSN reduction plan began in 2008 and will continue through 2012.

Providers may use either **DoD Benefits Numbers** (DBNs) or SSNs for identification purposes. The DBN is located on the back of the ID card at the top, next to the date of birth. Providers may still ask a TRICARE beneficiary for his or her sponsor's SSN, verbally or in writing, as required by individual office protocol.

Identification Cards for Family Members Age 75 and Older

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

Copying Identification Cards

To prevent identity theft and protect information from being used by individuals impersonating U.S. military personnel, TRICARE beneficiaries are instructed never to lose or allow others to use their CACs or ID cards.

However, it is legal and advisable for providers to copy CACs and ID cards for authorized purposes, which may include:*

- facilitating medical care eligibility determination and documentation
- cashing checks
- verifying TRICARE eligibility
- administering other military-related benefits

The DoD recommends providers retain photocopies of both sides of CACs and ID cards for future reference.

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

Important Notes about Eligibility

Active duty family members lose TRICARE eligibility at midnight on the day the active duty sponsor is separated from service, unless they are eligible for **Transitional Assistance Management Program** coverage or the sponsor is transitioning to a retired status.

Active duty service members are normally enrolled in TRICARE Prime or TPR. Once a member's eligibility is verified, care may be delivered and billed to TRICARE for payment. The service branch usually provides care for ADSMs at a military treatment facility (MTF) and pays for required civilian emergency or referred health care. Active duty service member claims must be submitted to Health Net for processing. See the *Claims Processing and Billing Information* section of this handbook for additional details.

TRICARE and Medicare Eligibility

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

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



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

Note: TRICARE covers ADSMs, regardless of Medicare eligibility. Medicare eligibility may continue up to eight and a half years beyond the date that Social Security disability benefits end. However, beneficiaries must continue to purchase Medicare Part B after disability benefits end to keep TRICARE coverage.

For more information about TFL, see "TRICARE For Life" later in this section.

Eligibility for TRICARE and Veterans Affairs Benefits

In some cases, beneficiaries are eligible for benefits under TRICARE and Department of Veterans Affairs (VA) programs. If a TRICARE beneficiary is also eligible for health care through the VA, he or she has the option to use either TRICARE or their VA benefits. Furthermore, TRICARE allows such beneficiaries to receive medically necessary care for the same episode of care, even if they have already been treated at the VA. However, TRICARE will not duplicate payments made by or authorized to be made by the VA for treatment of a service-connected disability.

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

TRICARE Health Care Program Options

TRICARE offers comprehensive medical and behavioral health benefits to all TRICARE beneficiaries. It is important to be aware of the [TRICARE program plan options](#) available according to beneficiary category.

TRICARE Prime Coverage Options

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

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

TRICARE Prime beneficiaries receive TRICARE Prime enrollment cards, and TPR beneficiaries receive TPR 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.

TRICARE Prime

TRICARE Prime is a managed care option available in TRICARE Prime Service Areas (PSAs). Each TRICARE Prime beneficiary is assigned or may select a primary care manager (PCM). Whenever possible, a PCM located at an MTF is assigned, but a TRICARE network civilian PCM may be assigned if an MTF PCM is not available.

TRICARE Prime beneficiaries should always seek non-emergency care from their PCMs, unless using the [point of service \(POS\) option](#). In most cases, TRICARE Prime beneficiaries must obtain a referral from their PCMs and Health Net to receive non-emergency care from another provider.

TRICARE Prime Remote

TRICARE Prime Remote (including TRICARE Prime Remote for Active Duty Family Members) provides TRICARE Prime coverage for ADSMs and family members who live with them in remote locations. Active duty service members and their families, who live and work more than 50 miles or a one-hour drive time from the nearest MTF, may be eligible to enroll in TPR. Each TPR beneficiary is assigned or may select a PCM. Whenever possible, a TRICARE network civilian PCM is assigned, but a non-network PCM may be assigned if a network provider is not available.



TRICARE Prime Remote beneficiaries should always seek non-emergency care from their PCMs, unless they are using the **POS** option. In most cases, TPR beneficiaries must obtain a referral from their PCMs and Health Net to receive non-emergency care from another provider. TRICARE Prime Remote beneficiaries without assigned PCMs should contact Health Net at **1-877-TRICARE (1-877-874-2273)** to coordinate their specialty care. TRICARE Prime Remote ADSMs may also require approval from the Military Medical Support Office (MMSO) service point of contact (SPOC) for non-emergency care. The SPOC determines referral management for ADSM fitness-for-duty care.

To determine if a particular ZIP code falls within a TPR coverage area, use the [TRICARE Prime Remote Zip Code Look-Up Tool](#).

TRICARE Prime and TRICARE Prime Remote Primary Care Managers

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

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

- certified nurse midwives
- family practitioners
- general practitioners
- internal medicine physicians
- nurse practitioners
- obstetricians/gynecologists
- pediatricians
- physician assistants

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

TRICARE Prime and TRICARE Prime Remote Point of Service Option

Point of service (POS) is an option that allows TRICARE Prime, TPR (non-active duty service member) and TYA Prime beneficiaries to obtain medically necessary TRICARE-covered services from any TRICARE-authorized provider (network or non-network), other than their PCM, without first obtaining a referral.

The POS option is applied when:

- A TRICARE Prime, TPR or TYA Prime beneficiary receives care from a network or non-network TRICARE-authorized provider without a referral from his or her PCM.

Note: TPR beneficiaries without an assigned PCM should contact Health Net at **1-877-TRICARE (1-877-874-2273)** to coordinate their specialty care.

- A TRICARE Prime, TPR or TYA Prime beneficiary self-refers to a civilian specialty care provider after a referral has been authorized by Health Net to an MTF specialty care provider.
- A TRICARE Prime, TPR or TYA Prime beneficiary self-refers to a non-network specialty care provider after a referral has been authorized by Health Net to a network specialty care provider.





The POS option does not apply in the following circumstances:

- Emergency services
- Preventive care services from a network provider
- The initial eight outpatient behavioral health therapy visits to a network provider
- Beneficiaries whose other health insurance is primary
- Newborn or adoptee care (A newborn or adoptee is covered as a TRICARE Prime/TPRADFM beneficiary for the first 60 days after birth or adoption, as long as one additional family member is enrolled in TRICARE Prime/TPRADFM or the sponsor is active duty.)
- Active duty service member care (Active duty service members who do not coordinate care through their PCM may be responsible for the entire cost of care.)
- Ancillary services (for example, diagnostic radiology and ultrasound services, diagnostic nuclear medicine services, pathology and laboratory services, and cardiovascular studies)

When using the POS option, beneficiaries must pay a deductible and 50 percent of the TRICARE allowable charge. Point of service costs do not apply to the catastrophic cap. The POS option does not affect provider reimbursement. For POS cost information, visit [Health Net's](#) website.

Note: Active duty service members cannot use the POS option and must obtain prior authorizations and referrals for civilian care. If an ADSM receives care without a prior authorization or referral, the claim is forwarded to the MMSO/SPOC for payment determination. If the MMSO/SPOC approves the care, the ADSM does not have to pay the bill. If the MMSO/SPOC does **not** approve, the ADSM is responsible for the entire cost of care.

TRICARE Standard

TRICARE Standard is a fee-for-service option that allows beneficiaries to seek care from any TRICARE-authorized non-network provider. TRICARE Standard is available to all TRICARE-eligible beneficiaries except ADSMs. Beneficiaries are responsible for annual deductibles and cost-shares. TRICARE Extra, which is a preferred provider option under TRICARE Standard,

allows beneficiaries to reduce out-of-pocket costs by using TRICARE network providers. For cost information, visit [Health Net's](#) website.

TRICARE Standard beneficiaries do not have PCMs and may self-refer to TRICARE-authorized providers. However, certain services (for example, inpatient admissions for substance use disorders and behavioral health, adjunctive dental care, home health services, and certain other services) require prior authorization from Health Net. See the *Health Care Management and Administration* section of this handbook for more information about prior authorization requirements.

TRICARE Young Adult

TRICARE Young Adult (TYA) offers TRICARE Prime, TRICARE Prime Remote or TRICARE Standard coverage depending on which option the beneficiary chooses. TRICARE Young Adult is a premium-based plan requiring enrollment and is available to young adult children of eligible uniformed service sponsors, and those under age 26 who have aged out of TRICARE at age 21 or 23 if a full-time college student. Those young adult children otherwise eligible cannot be married, a member of the uniformed services, qualified for an employer-sponsored health plan or eligible for other TRICARE coverage. Additional information about TYA can be found at www.hnfs.com.

TRICARE For Life

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

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



to avoid a break in TRICARE coverage and incurring Medicare monthly late enrollment premium surcharges.

TRICARE For Life beneficiaries must present a valid uniformed services ID card and a Medicare card prior to receiving services. If a TFL beneficiary's uniformed services ID card reads "NO" under the box titled CIVILIAN, he or she is still eligible to use TFL if he or she has both Medicare Part A and Part B. Copy both sides of the cards and retain the copies for your files. There is no separate TFL enrollment card. To verify TFL eligibility, call the TFL contractor, Wisconsin Physicians Service (WPS) at **1-866-773-0404**. You may call the Social Security Administration at **1-800-772-1213** to confirm a patient's Medicare status.

Note: Beneficiaries age 65 and older who are not eligible for premium-free Medicare Part A may remain eligible for TRICARE Prime (if residing in a PSA) or TRICARE Standard.

Refer to "TRICARE and Medicare Eligibility" in the *TRICARE Eligibility* section of this handbook for more information.

Note: Dependent parents and parents-in-law are not eligible for TFL.

How TRICARE For Life Works

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

If you have questions regarding how TRICARE will pay after Medicare, or to obtain prior authorization requirements, contact the TRICARE For Life contractor, WPS, at **1-866-773-0404**. If you have questions regarding Medicare benefits and coverage, contact Medicare at **1-800-MEDICARE (1-800-633-4227)**.

File TFL claims first with Medicare. Medicare pays its portion and electronically forwards the claim to WPS (unless the beneficiary has OHI). Wisconsin Physicians Service sends its payment for TRICARE-covered services directly to the provider. Beneficiaries will receive a Medicare Summary Notice and TRICARE explanation of benefits indicating the amounts paid.

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

See the *Claims Processing and Billing Information* section of this handbook for information about TFL claims and coordinating with OHI. For more information about TFL, call WPS at **1-866-773-0404** or visit the [WPS](#) website.

TRICARE for the National Guard and Reserve

The seven National Guard and Reserve components include:

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

Line of Duty Care for National Guard and Reserve Members

A **line of duty (LOD) condition** is determined by the military service and includes any injury, illness or disease incurred or aggravated while the National Guard or Reserve member is in a duty status, either inactive duty (such as reserve drill) or active duty.

This includes the time period when the military service member is traveling directly to or from the location where he or she performs military duty. The National Guard and Reserve member's service determines **LOD care**



eligibility, which is initiated by the member's unit medical representative. Because the Defense Enrollment Eligibility Reporting System (DEERS) does not show eligibility for LOD, the member receives a written authorization that specifies the LOD condition and terms of coverage. For Coast Guard members a notice of eligibility (NOE) is issued. It is the beneficiary's responsibility to ensure the LOD documentation is on file at either an MTF or the Military Medical Support Office (MMSO) and that MMSO authorizes all follow-up care.

Line of duty coverage is separate from transitional health care coverage under the Transitional Assistance Management Program (TAMP), Transitional Care for Service-Related Conditions (TCSRC) program or coverage under the TRICARE Reserve Select (TRS) health program option.

Whenever possible, MTFs provide care to National Guard and Reserve members with LOD conditions. Military treatment facilities may refer National Guard and Reserve members to civilian TRICARE providers. If there is no MTF nearby to deliver or coordinate care, MMSO may coordinate non-emergency care with any TRICARE-authorized network provider.

The provider should submit medical claims directly to Health Net unless otherwise specified on the LOD-written authorization or requested by the National Guard or Reserve member's Medical Department Representative. Health Net forwards any claim not referred by an MTF or pre-approved by MMSO to MMSO for approval or denial.

If MMSO denies a claim for eligibility reasons, the provider's office should bill the member. The MMSO may approve payment once the appropriate eligibility documentation is submitted.

Coverage When Activated for More Than 30 Consecutive Days

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

Family members of National Guard and Reserve members also may become eligible for TRICARE if the National Guard or Reserve member (sponsor) is called to active duty for more than 30 consecutive days. These family members may enroll in TRICARE Prime or TPR, depending on location, or they may use TRICARE

Standard. They are also eligible for dental coverage through the TRICARE Dental Program. Sponsors must register their family members in DEERS to establish TRICARE eligibility.

TRICARE Reserve Select and TRICARE Retired Reserve

TRICARE Reserve Select (TRS) is a premium-based health plan offered by the DoD to qualified members of the Selected Reserve of the Ready Reserve.

TRICARE Retired Reserve (TRR) is a premium-based health plan offered by the DoD to eligible members of the Retired Reserve. TRICARE Reserve Select and TRR offer comprehensive health care coverage and have similar patient cost-shares and deductibles to TRICARE Standard, but beneficiaries must pay monthly premiums. These beneficiaries may self-refer to any TRICARE-authorized provider; however, certain services (for example, inpatient admissions for substance use disorders and behavioral health, adjunctive dental care, home health services) require prior authorization from Health Net. See the *Health Care Management and Administration* section of this handbook for more information about prior authorization requirements.

After purchasing either member-only or member and family TRS or TRR coverage, beneficiaries receive 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. Visit [Health Net's website](#) or call Health Net's toll-free TRS and TRR number at **1-800-555-2605** and use the IVR feature to verify coverage status.

Note: Eligible young adults of sponsors who have TRS or TRR coverage can enroll in TRICARE Young Adult Standard.

TRICARE Pharmacy Program

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



TRICARE beneficiaries have the following options for filling prescriptions:

- **Military treatment facility pharmacies** – Using an MTF pharmacy is the least expensive option, but formularies may vary by MTF pharmacy. Contact the local MTF pharmacy to check availability before prescribing a medication.
- **TRICARE Pharmacy Home Delivery** – The TRICARE Pharmacy Home Delivery mail order option is the preferred method when not using an MTF pharmacy especially for beneficiaries using maintenance medications.
- **TRICARE retail network pharmacies** – Beneficiaries can access a large network of retail pharmacies in the United States and certain U.S. territories (Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).
- **Non-network retail pharmacies** – Filling prescriptions at a non-network retail pharmacy is the most expensive option and is not recommended for beneficiaries.

For more information about benefits and costs, visit the [TMA](#) or [Express Scripts](#) websites or call Express Scripts at **1-877-363-1303**.

Member Choice Center

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

To learn more about the Member Choice Center, call Express Scripts at **1-877-363-1303** or access information online by visiting the [TMA](#) or [Express Scripts](#) websites.

Quantity Limits

TRICARE has established quantity limits on certain medications, which means the Department of Defense (DoD) pays up to a specified amount of medication each time the beneficiary fills a prescription. Quantity limits are often applied to ensure medications are safely and appropriately used. Exceptions to established quantity limits may be made if the prescribing provider is able to justify medical necessity. Use the [TRICARE Formulary Search Tool](#) for a list of TRICARE-covered prescription drugs that have quantity limits.

Prior Authorizations for Medications

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

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

Generic Drug Use Policy

It is DoD policy to use generic medications instead of brand-name medications whenever possible. A brand-name drug with a generic equivalent may be dispensed only after the prescribing physician completes a clinical assessment that indicates the brand-name drug is medically necessary and after Express Scripts grants approval. If your patient requires a brand-name medication that has a generic equivalent, you must obtain 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.

Uniform Formulary Drugs and Non-Formulary Drugs

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



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

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

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

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

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

Step Therapy Medication

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

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

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

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

Pharmacy Options for Medicare-Eligible Beneficiaries

Medicare-eligible beneficiaries are able to use the TRICARE Pharmacy Program benefits. However, TRICARE beneficiaries who turned 65 on or after April 1, 2001, are required to be enrolled in Medicare Part B. If they choose not to enroll, their pharmacy benefit is limited to the medications available at MTF pharmacies.*

Medicare-eligible beneficiaries are also eligible for Medicare Part D prescription drug plans. However, they do not need to enroll in a Medicare Part D prescription drug plan to keep their TRICARE benefit. You can direct your patients to visit TRICARE Management Activity's (TMA) **Medicare Part D** page for additional details. For the most current information about Medicare Part D, call Medicare at **1-800-Medicare (1-800-633-4227)** or visit the **Medicare** website.

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



Pharmacy Data Transaction Service

The Pharmacy Data Transaction Service (PDTS) is a centralized data repository that records information about DoD beneficiaries' prescriptions. The PDTS allows providers to access complete patient medication histories, helping to increase patient safety by reducing the likelihood of adverse drug-drug interactions, therapeutic overlaps and duplicate treatments. The PDTS conducts an online prospective drug utilization review (a clinical screening) in real time against a beneficiary's complete medication history for each new or refilled prescription before it is dispensed to the patient. Regardless of where a beneficiary fills a prescription, prescription information is stored in a robust central data repository and is available to authorized PDTS providers, including MTF pharmacies, MTF providers, TRICARE retail network pharmacies, and TRICARE Pharmacy Home Delivery.

Specialty Medication Care Management

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

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

This voluntary program provides:

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

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

Beneficiaries enrolled in the SMCM program may contact pharmacists 24 hours a day, seven days a week. The specialty clinical team reaches out to the 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 pre-populated enrollment forms.

If a patient requires specialty pharmacy medications, you may fax the prescription to Express Scripts at **1-877-895-1900**. Express Scripts ships medications to the beneficiary's home. Faxed prescriptions must include the following identifying information: patient's full name, date of birth, address, and ID number.

Note: Some specialty medications may not be available through TRICARE Pharmacy Home Delivery because the manufacturer limits the drug's distribution to specific pharmacies. If you submit a prescription for a limited-distribution medication, Express Scripts either forwards the prescription to a pharmacy of the patient's choice that can fill it or provides the patient with instructions about where to send the prescription. To determine if a specialty medication is available through TRICARE Pharmacy Home Delivery, use the **TRICARE Formulary Search Tool**. Specialty drugs not available through Express Scripts will require prior authorization and may be ordered through **CuraScript's website**.

1:1:1 Program for Unsafe Controlled Medication

TRICARE beneficiaries who may be misusing or abusing controlled medications are identified and referred to the 1:1:1 Program by Express Scripts or Health Net Case Management. Factors taken into consideration include the number of controlled medications the beneficiary uses, the number of physicians prescribing the medications, and the number of different pharmacies filling the prescriptions.



If the beneficiary refuses Case Management or does not respond to the requests for contact, the beneficiary is placed into the 1:1:1 Program. The beneficiary must choose one prescribing provider, one pharmacy, and one hospital to receive medical services and prescriptions for his or her controlled medications.

If the beneficiary designates a prescribing provider, prescriptions for controlled substances written by the designated provider will be processed without further review.

If the beneficiary does not designate a prescribing provider and a hospital, or seeks services from someone other than his/her designated provider or hospital for his/her controlled medications, his/her claims for certain health care services may be denied and he/she will be responsible for 100 percent of pharmacy costs for all controlled medications.

TRICARE Dental Options

The TRICARE health care benefit covers adjunctive dental care (dental care that is medically necessary to treat a covered medical condition). However, several non-adjunctive dental care options are available to eligible beneficiaries. Active duty service members receive dental care at military dental treatment facilities (DTF) or from network providers through the TRICARE Active Duty Dental Program (ADDP), if necessary. For all other beneficiaries, TRICARE offers two 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 ages five years and younger. See the *Medical Coverage* section of this handbook for more details.

TRICARE Active Duty Dental Program

The ADDP is administered by United Concordia Companies, Inc. and provides civilian dental care to ADSMs who are referred for care by a military DTF or who serve and reside greater than 50 miles from a DTF. Visit the [TMA](#) website for more information.

TRICARE Dental Program

The TDP, administered by Metropolitan Life Insurance Company (MetLife), 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. Active duty service members (and National Guard and Reserve members called to active duty for a period of more than 30 consecutive days or eligible for the pre-activation benefit up to 90 days prior to their report date) are not eligible for the TDP. They receive dental care at military DTFs or through the ADDP. Visit the [TMA](#) website for more information.

TRICARE Retiree Dental Program

The TRICARE Retiree Dental Program (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. Visit the [TMA](#) website for more information.

Delta Dental[®] is a registered trademark of Delta Dental Plans Association. All rights reserved.

Cancer Clinical Trials

There are three types of covered NCI-sponsored **cancer clinical trials** for eligible beneficiaries:

- **Phase I trials** – study the safety of an agent or intervention for the prevention, screening, early detection, and treatment of cancer.
- **Phase II trials** – 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** – compare a promising new treatment against the standard approach. These studies also focus on a particular type of cancer.



Trial Costs

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

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

Trial Participation

Participation in NCI clinical trials requires prior authorization. Visit the [NCI](#) website for a list of some, but not all, of the Phase I, II and III NCI-sponsored cancer clinical trials. You must contact the TRICARE North Region Cancer Clinical Trials Coordinator at **1-800-395-7821** before beginning evaluation or treatment under a clinical trial.

TRICARE Extended Care Health Option

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

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

- moderate to severe mental retardation
- a severe physical disability
- a severe physical or psychological condition that results in the beneficiary's homebound status

- two or more disabilities affecting separate body systems such that one disability alone is not an ECHO qualifying condition (for example, a beneficiary with a combination of a mild hearing and vision impairment)

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

Beneficiaries must be registered to be eligible for ECHO benefits. There is no retroactive registration for the ECHO program. Visit Health Net's [Registering in Extended Care Health Option](#) website page for more information.

ECHO Provider Responsibilities

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

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

Additionally, providers rendering applied behavior analysis (ABA) must be:

- TRICARE authorized
- State-licensed to provide ABA services*
- State-certified Applied Behavior Analysts*

* If state licensure or certification is not available, providers must be certified by the Behavior Analyst Certification Board as either Board Certified Behavior Analysts (BCBA) or Board Certified Behavior Analysts – D (BCBA-D). Board Certified Assistant Behavior Analysts are not TRICARE authorized providers under the ECHO program.

Note: Under the DoD Enhanced Access to Autism Services Demonstration, non-certified paraprofessional providers may render certain educational interventions for Autism Spectrum Disorders services 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 services and supplies:

- Applied behavior analysis (ABA) therapy under the Autism Services Demonstration and other types of special education that are not available through local community resources
- Medical and rehabilitative services not specifically covered under the basic TRICARE benefit
- Training, including how to use assistive technology devices such as a specialized computer keyboard
- Vocational support such as classes that teach a beneficiary to become more independent with life skills
- Family training to assist in the management of the beneficiary's qualifying condition – for example, training a family member to use the ECHO beneficiary's specialized equipment, ABA therapy and alternative communication methods
- Institutional care when the severity of the qualifying condition requires protective custody or training in a residential environment
- Private transportation to and from an ECHO-authorized service for institutionalized ECHO beneficiaries – for example, mileage reimbursement to transport the institutionalized ECHO beneficiary to and from an ECHO-authorized service
- Assistive services, such as those from a qualified interpreter or translator for beneficiaries who are deaf or mute – for example, readers for the blind and sign language interpreters to assist in receiving ECHO-authorized services
- Durable equipment – for example, a wheelchair tray or bath chair
- Durable equipment adaptation and maintenance
- Extended Care Health Option respite care – up to 16 hours of care within the month that another ECHO benefit is authorized and rendered

ECHO Home Health Care Benefits

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

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

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

ECHO Costs and Catastrophic Cap Information

TRICARE ECHO beneficiaries have a monthly cost-share based upon the sponsor's pay grade during the months services are used.

The sponsor/beneficiary is responsible for the monthly cost-share plus any amount in excess of the government's maximum coverage. The cost-share applies only once per month, not per service. If there is more than one family member receiving ECHO services, only one cost-share is required.

The monthly cost-share is paid directly to the ECHO authorized provider. The cost-share under ECHO is in addition to those incurred for services and items received through the TRICARE Prime, TPR and TRICARE Standard options. Cost-shares under ECHO do not accrue to the catastrophic cap or deductible.

The maximum government cost-share is \$36,000 per FY per beneficiary for benefits under the ECHO program. The ECHO Home Health Care (EHHC) skilled services and ECHO Home Health Care (EHHC) respite benefits are not included in these cap amounts. Coverage for the EHHC skilled services and EHHC respite care benefits are capped on a fiscal year basis.



For more information about TRICARE ECHO, visit Health Net's [Extended Care Health Option](#) website page or refer to the [TRICARE Policy Manual, Ch. 9](#).

DoD Enhanced Access to Autism Services Demonstration

The **DoD Enhanced Access to Autism Services Demonstration** (Autism Services Demonstration) provides TRICARE reimbursement for Educational Interventions for Autism Spectrum Disorders services delivered by paraprofessional providers. Beneficiaries must register in ECHO to participate in the Autism Services Demonstration.

The Autism Services Demonstration provides information that will enable the DoD to determine the following:

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

The Autism Services Demonstration allows non-certified paraprofessional providers or tutors to provide autism services (in particular, ABA therapy), under the supervision of TRICARE-authorized certified therapists, to ADFMs in the 50 United States and District of Columbia. Authorized supervisors are required to direct and oversee tutors who provide services and must verify that tutors are trained and able to perform the services required to treat children with autism.

Note: Allowed costs for Autism Services Demonstration services count toward the ECHO cap limit of \$36,000 per beneficiary, per FY. For more information about the Autism Services Demonstration, visit Health Net's [Autism Services Demonstration](#) website page.

Supplemental Health Care Program

The **Supplemental Health Care Program (SHCP)** provides coverage by civilian health care providers to ADSMs and designated non-TRICARE eligible patients. Although prior authorizations and claims processing are administered by the TRICARE contractors (e.g., Health Net), it is funded separately by the Department of Defense (DoD) and follows different rules than TRICARE.

The following individuals are eligible for the SHCP:

- active duty service members assigned to MTFs
- active duty service members on travel status (for example, leave, temporary assignment to duty or permanent change of station) with the exception of those enrolled in TPR
- Navy and Marine Corps service members enrolled to deployable units and referred by the unit PCM (non-MTF)
- National Guard and Reserve members on active duty
- National Guard members (LOD care only, unless member is on active federal service)
- National Oceanic and Atmospheric Administration personnel, U.S. Public Health Service personnel, ROTC students, cadets or midshipmen, and eligible foreign military personnel
- non-active duty Medicare-eligible beneficiaries when they are inpatients in an MTF and are referred to civilian facilities for tests or procedures unavailable at 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
- 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**



The SHCP covers prior authorized or referred care by the MTF and/or the TRICARE Management Activity Deputy Director. The TRICARE Management Activity Deputy Director may authorize services for active duty service members that are not TRICARE benefits. When SHCP beneficiaries need care, they are referred to network providers as needed. For non-MTF referred care, the SPOC determines if the ADSM receives care from an MTF or network provider.

Supplemental Health Care Program beneficiaries are not responsible for copayments, cost-shares or deductibles. See the *Claims Processing and Billing Information* section of this handbook for SHCP claims submission information.

Transitional Health Care Benefits

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

Continued Health Care Benefit Program

The **Continued Health Care Benefit Program** (CHCBP) is a premium-based health care program administered by Humana Military Healthcare Services, Inc. (Humana Military). The CHCBP offers temporary transitional health care coverage (18–36 months) after TRICARE eligibility ends and acts as a bridge between military health care benefits and the beneficiary's new civilian health care plan. Continued Health Care Benefit Program benefits are comparable to TRICARE Standard, but differences do exist. The main difference is that beneficiaries must pay quarterly premiums. Additionally, under CHCBP, providers are not required to use or coordinate with MTFs, and MTF non-availability statements are no longer required.

Providers must coordinate with Humana Military to obtain prior authorizations and referrals for CHCBP beneficiaries. Medical necessity rules for CHCBP beneficiaries follow TRICARE Standard guidelines. Call Humana Military at **1-800-444-5445** to coordinate CHCBP prior authorizations and referrals or fax information to **1-877-270-9113**.

For more information about CHCBP, visit Humana Military's **Continued Health Care Benefit Program** page or call **1-800-444-5445**. Health Net cannot provide CHCBP assistance or information.

Transitional Assistance Management Program

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

Qualifying beneficiaries may enroll in TRICARE Prime if they reside in a Prime Service Area (PSA), or they are automatically covered under TRICARE Standard. Rules and processes for these programs apply, and beneficiaries are responsible for ADFM costs.

Transitional Assistance Management Program beneficiaries must present valid uniformed services ID cards or CACs at the time of service. See the *TRICARE Eligibility* section of this handbook for information about verifying eligibility.

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

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

Transitional Care for Service-Related Conditions Program

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

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

Transitional Care for Service-Related Conditions applies only to the specific service-related condition and must be:



- diagnosed during TAMP coverage
- able to be resolved within 180 days
- approved by the Department of Defense (DoD)

Note: Once the DoD validates a medical condition eligible for TCSRC, coverage will show in the Defense Enrollment Eligibility Reporting System.

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

Beneficiaries should mail the worksheet and all other supporting documentation, as well as a TCSRC request letter, to the Military Medical Support Office at:

TRICARE Management Activity
Military Medical Support Office
1637 Central Cell
PO Box 886999
Great Lakes, IL 60035-6999

For more information on TCSRC, visit the [Transitional Care for Service-Related Conditions](#) page on TRICARE Management Activity's website.





Medical Coverage



TRICARE only covers health care services and devices that are medically necessary and considered proven. Some types of care have limitations. Beneficiary liability for covered services varies according to program option (**TRICARE Prime, TRICARE Prime Remote [TPR], TRICARE Standard, and TRICARE for Life [TFL]**). See "TRICARE Program Options" in the *TRICARE Eligibility* section of this handbook for specific beneficiary liability information.

This section provides an overview of TRICARE covered services and includes specific details about certain benefits. **This section is not all-inclusive and services listed as TRICARE-covered services are subject to change.**

For additional information or specific questions about TRICARE covered services, visit Benefits A to Z on www.hnfs.com or contact Health Net Federal Services, LLC (Health Net) at **1-877-TRICARE (1-877-874-2273)**. You can also review the **TRICARE Provider News** newsletter for articles about benefits and program changes.

Some military treatment facilities (MTFs) may offer services or procedures that TRICARE does not cover. Beneficiaries should contact their local MTF for information about these services. TRICARE Management Activity Deputy Director may authorize services for active duty service members that are not TRICARE benefits. Providers are reimbursed for these services only if they obtain prior authorization from Health Net for these services.

Network Utilization

TRICARE network or MTF providers should be the first option in TRICARE beneficiary care. In most cases, beneficiary care can be arranged swiftly through the TRICARE provider network while meeting access to care standards. Requests for specialty care referrals or outpatient treatment authorizations to non-network providers will be redirected to TRICARE network providers of the same specialty whenever possible.

Items that have limitations may have alternative health care resources. View Health Net's **Alternative Health Care Resources** page for additional information.

Note: Providers requesting coverage for limited benefits can refer to the Health Net **Letter of Attestation** page for additional authorization information.

Covered Services

Adjunctive Dental Care

Dental benefits are available under the separate **TRICARE dental programs**. Limited adjunctive dental services may be covered when related to other covered medical care.

Prior authorization is required for all beneficiaries before receiving any adjunctive dental treatment to ensure the services will be covered. The prior authorization requirement is waived only when essential adjunctive dental care involves a medical emergency, such as facial injuries resulting from a car accident.

Some of the adjunctive dental procedures TRICARE may cover include:

- Removal of teeth and tooth fragments to treat and repair facial trauma, or for example, treatment of a fractured jaw.
- Total or complete ankyloglossia (tongue-tie) to alleviate difficulty swallowing or speaking.
- Dental or orthodontic care directly related to the medical and surgical correction of a severe congenital anomaly.
- Dental care in preparation for, or as a result of, inline radiation therapy for oral or facial cancer.

The following are special circumstances covered under the adjunctive dental care benefit:

- Facility services required to safe guard the life of the beneficiary – Some patients have medical conditions that could become life-threatening



during routine dental procedures (for example, tooth extraction for a hemophiliac). TRICARE covers the facility services and supplies.

- Children age five or younger or beneficiaries with severe disabilities – Children age five and under, and beneficiaries with severe developmental, mental or physical disabilities undergoing routine dental procedures. TRICARE covers the facility services, supplies and anesthesiology services. Under this category, TRICARE does not cover the professional dental services and anesthesiology services rendered by the attending dentist. TRICARE will cover anesthesiology services rendered by a separate anesthesiology provider.

Note: Acute anxiety, behavioral issues or extensive dental treatment do not qualify beneficiaries for adjunctive dental care.

Allergy Services

Allergy shots and testing are covered benefits. This includes the services and supplies required in the diagnosis and treatment of allergies. Allergy preparations, also referred to as the mixing of the serum for allergy injections, are a covered benefit if performed and administered during the office visit. See Health Net's [asthma and allergy toolkit](#) for additional resources and ways to control allergies.

Ambulance Services

Ambulance services are generally covered when medically necessary. TRICARE covers the following ambulance services:

- emergency transport to a hospital
- transfers from one hospital to another hospital more capable of providing the required care as ordered by a physician
- transfers from an emergency room to a hospital more capable of providing the required care
- transfers between a hospital or skilled nursing facility* (SNF) and another facility for outpatient therapy or diagnostic services ordered by a physician
- transfers to and from a SNF when medically indicated

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

Note: Transports or transfers must be to the closest facility capable of providing the required care.

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 beneficiary to the nearest hospital with appropriate facilities, and the beneficiary's medical condition warrants speedy admission or is such that transfer by other means is not advisable.

Ambulatory Surgery (Same Day)

Ambulatory surgery (same day) is covered when done at a hospital-based or freestanding ambulatory surgical center that is TRICARE-certified. The surgery must be medically necessary and for a medical condition that is covered by TRICARE.

Applied Behavior Analysis Therapy

Applied behavior analysis (ABA) therapy uses behavioral modification therapy techniques to modify behavior as part of a learning or treatment process. The TRICARE basic program now covers ABA therapy as an interim benefit due to a recent U.S. District Court decision.

Under the TRICARE basic program, ABA therapy allows TRICARE-authorized providers to perform one-on-one therapy to all eligible TRICARE beneficiaries. This benefit is separate from the Autism Services Demonstration that still exists under the Extended Care Health Option (ECHO) program. Some benefit exclusions apply – see "Exclusions" in this section.

Learn more about the [Autism Services Demonstration](#) under the ECHO program.

Prior Authorization and Eligibility

No prior authorization is required for the interim ABA therapy benefit. However, referral requirements for ABA therapy under the TRICARE basic program will follow the same rules for office visit referrals based on plan type (for example: TRICARE Prime).

TRICARE beneficiaries must have an autism spectrum disorder (ASD) diagnosed by a TRICARE-authorized primary care manager or by a specialized ASD provider defined as a:



- Physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology, or child psychiatry; or
- Ph.D. clinical psychologist working primarily with children.

Autism spectrum disorders are:

- Asperger's syndrome
- autistic disorder
- childhood disintegrative disorder
- pervasive developmental disorder (not otherwise specified)
- Rett syndrome

ABA therapy services covered under the TRICARE basic program:

- initial beneficiary assessment
- development of a treatment plan
- one-on-one therapy
- training of immediate family members to provide services in accordance with the treatment plan
- monitoring the progress towards treatment goals
- meetings to review progress with family members

Provider Requirements

Only a qualified provider may provide services.

Additionally, qualified ABA providers must be referred by and work under supervision of a TRICARE-authorized primary care manager/provider, board-certified or board-eligible behavioral developmental pediatrician, neurodevelopmental pediatrician, pediatric neurologist, child psychiatrist, or clinical psychologists, working primarily with children. To be a qualified ABA provider, the provider must:

- have a current state license to provide services; or
- be currently state-certified as an applied behavioral analyst; or
- be certified by the Behavioral Analyst Certification Board (BACB) as a board-certified behavior analyst (BCBA) when a state license or certification is not available; and

- meet all applicable requirements of TRICARE-authorized providers.

Note: Individuals certified by the BACB as a board-certified assistant behavior analyst (BCaBA) are not eligible TRICARE-authorized providers under the TRICARE basic program.

Reimbursement

The following codes are eligible for reimbursement under the TRICARE basic program:

- Initial assessment, development of initial treatment plan and one-on-one therapy will be billed using HCPCS code S5108, per 15 minutes.
- Development of an updated treatment plan will be billed using CPT® code 99080.
- Conducting progress meetings will be billed using CPT procedure code 90887.

Reimbursement will be the lesser of the TRICARE allowable charge, \$125 per hour, the negotiated rate or the billed charge. Current authorizations under ECHO using CPT code 99199 will follow this reimbursement methodology.

This benefit is retroactive to February 16, 2010. Claims for services rendered after February 16, 2010, can be submitted for reimbursement. To learn more on how to submit claims, visit PGBA's [Electronic Filing Options](#) or Health Net's [Submitting Paper Claims](#) pages.

Filing claims

In order to reduce claim errors and receive faster claim payments, providers should use the following guidelines:

When filing an electronic claim using HCPCS S5108, write in the Notes section whether services provided were for:

- educational interventions for autism spectrum disorders supervision (EIA supervisor) or
- basic therapy.

If you are filing a hardcopy claim, please write whether services were "supervision" or "basic therapy" next to where you fill out HCPCS S5108 on the form.

Aquatic Therapy

Aquatic therapy, also referred to as hydrotherapy, may be a TRICARE covered benefit if prescribed by a



physician and provided as part of **physical therapy** or **occupational therapy**.

Bariatric (Weight Loss) Surgery

Gastric bypass, gastric stapling, gastroplasty, vertical banded gastroplasty and laparoscopic adjustable gastric banding may be covered benefits when the following conditions are met:

- Beneficiary must be age 18 and older or have documentation of completed bone growth, and
- There is a medical record documentation indicating previous attempts for non-surgical treatment of obesity were unsuccessful, and
- Body mass index is greater than or equal to 40 kg/m² or
- Body mass index is 35-39.9 kg/m² and the beneficiary has been diagnosed with one of the following comorbidities: cardiovascular disease, type 2 diabetes mellitus, obstructive sleep apnea, pickwickian syndrome, hypertension, coronary artery disease, obesity-related cardiomyopathy or pulmonary hypertension. Other clinically significant co-morbidities may be considered on a case-by-case basis.

A pre-operative psychological evaluation and **psychological testing**, six hours or less, are covered benefits as part of the initial assessment to determine if the individual meets the requirements for surgery. This psychological evaluation as part of the psychological testing does not count toward the initial eight outpatient behavioral health therapy visits.

TRICARE Prime beneficiaries require prior authorization for all weight loss procedures.

For TRICARE Standard beneficiaries, we recommend providers submit a **request for prior authorization** to determine if TRICARE requirements are met.

Revision procedures related to bariatric surgery require medical necessity review. Providers should submit a **request for prior authorization** to determine if TRICARE requirements are met. Some benefit exclusions apply – see "Exclusions" in this section. There is a once per lifetime limit on weight loss surgery.

Bedwetting Alarm

Bedwetting alarm for the treatment of primary nocturnal enuresis may be considered for cost-sharing when prescribed by a physician and after physical or organic causes for nocturnal enuresis have been ruled out.

Biofeedback

Biofeedback may be covered if all of the following are met:

- Given in connection with electrothermal, electromyograph or electrodermal biofeedback therapy
- When there is documentation that the patient has undergone an appropriate medical evaluation
- When the patient's present condition is not responding to or no longer responds to other forms of conventional treatment
- Only provided in treatment of Raynaud's Syndrome or as an adjunctive treatment for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, or incapacitating muscle spasm or weakness

Birth Control

The following forms of birth control are covered:

- prescription contraceptives
- PREVEN Emergency Contraceptive Kit
- injectable contraceptives such as Depo-Provera (medroxyprogesterone acetate)
- implantable contraceptives, if FDA-approved as an implantable contraceptive, such as Implanon
- intrauterin devices (IUDs)*, if FDA-approved, including surgical insertion, removal and replacement (may be inserted during a well-woman exam)
- contraceptive diaphragms*, including related professional services for measurements and placement, removal or replacement
- surgical sterilization (for example, tubal ligation also known as tubes tied, and vasectomy)
- permanent birth control such as Essure or Adiana

*IUD insertion or diaphragm fitting services not performed during a **preventive exam** may require an approval from Health Net for all TRICARE Prime beneficiaries.



See Health Net's [Birth Control Guide](#) to help select a method of birth control that's right for your beneficiary.

Birthing Center Care

See [maternity care](#).

Blood Lead Testing

Blood lead testing, an assessment of risk for lead exposure, is a covered benefit when performed during well-child care visits from six months to six years for all children determined to be high-risk.

Bone Density Study (dexascan)

Bone density study, also known as a DXA or Dexascan, is covered for:

- the diagnosis and monitoring of suspected or confirmed osteoporosis,
- the diagnosis and monitoring of osteopenia,
- the diagnosis of patients with signs and symptoms of bone disease, or
- the screening of patients considered to be at risk for developing osteoporosis.

Botox Injections

Injections of botulinum toxin type A, also known as Botox®, are a limited benefit.

Botulinum toxin type A injections may be covered for the following:

- Prophylaxis of migraine headaches in patients 18 years of age and older, who have migraines 15 days or more per month with headache lasting four hours a day or longer.
- Strabismus for patients 12 years of age and older.
- Blepharospasm for patients 12 years of age and older.
- Facial myokymia (craniofacial dystonia) for patients 12 years of age and older.
- Oromandibular (jaw-closing) dystonia.
- Laryngeal dystonia (spasmodic dysphonia).

- Cervical dystonia (repetitive contraction of the neck muscles) for patients 16 years and older.
- Axillary hyperhidrosis (severe underarm sweating) that cannot be managed by topical agents for patients 18 years of age and older.
- Spasticity resulting from cerebral palsy.
- Upper limb spasticity for patients 18 years of age and older.
- Sialorrhea (excessive salivation or drooling) associated with Parkinson's disease, for patients refractory to or unable to tolerate systemic anticholinergics.
- Chronic anal fissure if unresponsive to conservative therapeutic measures.

Botulinum toxin type B, also known as Myobloc, may be covered for the treatment of sialorrhea associated with Parkinson's disease.

Botulinum toxin injections are not covered for headaches except as noted above and not covered for myofascial pain, fibromyalgia, low back pain, palmar hyperhidrosis or urinary urge incontinence. Botox® injections are not covered when used for cosmetic procedures.

Note: Providers requesting coverage of Botox A for treatment of migraines and upper limb spasticity can refer to the [Letter of Attestation](#) page for additional authorization information.

Breast Implant Removal

Breast implant removal is a limited benefit. It may be covered in very limited circumstances, such as when implants are used during breast reconstructive surgery after breast cancer treatment.

Breast Magnetic Resonance Imaging

Coverage of a breast Magnetic Resonance Imaging, also known as an MRI, (CPT® 77058 and 77059) depends on whether the service is a preventive screening or a diagnostic procedure due to symptoms or a confirmed diagnosis.

Screening Breast MRI

Screening breast MRIs are covered annually in addition to the annual [screening mammogram](#), beginning at age 30 for beneficiaries considered to be at high risk of developing breast cancer. High-risk indicators are:



- A lifetime risk of breast cancer of 20 percent or greater using standard risk assessment models such as: Gail model, Claus model or Tyrer-Cuzick.
- Known BRCA1 or BRCA2 gene mutation.
- A parent, child or sibling with a BRCA1 or BRCA2 gene mutation, and the beneficiary has not had genetic testing for this mutation.
- Radiation therapy to the chest between 10-30 years of age.
- History of LiFraumeni, Cowden or Bannayan-Riley-Ruvalcaba syndrome, or a parent, child or sibling with a history of one of these syndromes.

Note: See **Laboratory Developed Tests (LDTs)** for BRACAnalysis® coverage.

Diagnostic Breast MRI

Diagnostic breast MRIs are covered for the following:

- detection of breast implant rupture (the implantation of the breast implants must have been covered by TRICARE)
- detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography
- presurgical planning for locally advanced breast cancer before and after completion of neoadjuvant chemotherapy to permit tumor localization and characterization
- presurgical planning to evaluate the presence of multicentric disease in patients with locally advanced cancer who are candidates for breast conservation treatment
- evaluation of suspected cancer recurrence
- determination of the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor

Breast Prosthesis

Breast prostheses are a covered benefit as **durable medical equipment**. TRICARE allows one initial prosthesis per missing body part. Replacements may be covered after benefit review to determine reason for replacement. See also **mastectomy bras**.

Breast Pumps

Heavy duty hospital grade electric breast pumps are covered (including services and supplies related to the use of the pump) for the mother of a premature infant while the premature infant remains hospitalized during the immediate postpartum period. A physician must document the medical reason for an electric breast pump after the infant has been discharged.

Cancer Clinical Trials

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

Prior authorization is required before the initial evaluation and should be requested from the TRICARE North Clinical Trials Coordinator at **1-800-395-7821**. The institutional and individual providers must be TRICARE-authorized and treatments are NCI-sponsored Phase I, Phase II and Phase III protocols. Covered services include:

- Phase I, Phase II and Phase III clinical trials sponsored by NCI
- All medical care and testing required to determine eligibility for an NCI-sponsored trial, including the evaluation for eligibility
- All medical care required as a result of participation in a clinical trial
- Purchase and administration of all approved chemotherapy agents (except for NCI funded investigational drugs)
- All inpatient and outpatient care
- Diagnostic and laboratory services

Cardiac Rehabilitation

Cardiac rehabilitation may be covered for hospital-based acute rehabilitation, including inpatient hospitalization and up to 36 outpatient sessions per cardiac event.

One of the following events must have occurred in the preceding 12 months:



- Myocardial infarction
- Coronary artery bypass graft
- Coronary angioplasty
- Percutaneous transluminal coronary angioplasty
- Chronic stable angina (limited to 36 sessions in a calendar year)
- Heart valve surgery
- Heart transplants, to include heart-lung

Cardiovascular Screening

Cardiovascular disease screenings are a covered benefit, and include cholesterol and blood pressure checks. Cholesterol testing is a covered benefit once every five years beginning at age 18. TRICARE recommends blood pressure checks for children annually between ages three to five and every two years thereafter; and for adults a minimum every two years.

Chelation Therapy

Chelation therapy is covered if the chelating agent is approved by the U.S. Food and Drug Administration (FDA) and used for an FDA-approved indication. Chelation therapy is a covered benefit when used to treat heavy metal toxicity, such as lead poisoning.

Chemotherapy and Radiation Treatment

Chemotherapy and radiation for the treatment of cancer is a covered benefit. Chemotherapy agents must be approved by the U.S. Food and Drug Administration (FDA) and used for an FDA-approved indication or considered a standard of care. See also [Cancer Clinical Trials](#).

Cholesterol Testing

A lipid panel for cholesterol testing is covered as recommended by the [National Heart, Lung and Blood Institute](#).

Circumcision, Newborn

Circumcision is covered as part of the inpatient services for a newborn. If a circumcision is performed after the child has been discharged from the hospital and is provided in an office visit setting, it is cost-

shared with [office visit costs](#). If it is performed in an outpatient hospital or ambulatory surgery facility it is cost-shared with [ambulatory surgery costs](#).

Cochlear Implants

Implantation, to include the implants and the external speech processor device, is a covered benefit if approved by the U.S. Food and Drug Administration (FDA) and when used for approved indications. Cochlear implants are not covered if there is a contraindication for the surgery such as a middle ear infection, a lesion in the auditor nerve, poor anesthetic risk, severe mental retardation, severe psychiatric disorders, or organic brain syndrome. See also [hearing aids](#).

Colonoscopy, Proctosigmoidoscopy or Flexible Sigmoidoscopy

Routine colonoscopy, proctosigmoidoscopy or sigmoidoscopy performed for colorectal cancer screening, in the absence of cancer or other presenting signs, is a limited benefit.

Colonoscopy

Optical, also known as conventional, colonoscopies for the screening of colorectal cancer are covered in the following circumstances:

Average risk:

One every 10 years at age 50 and older.

Increased risk:

- One every five years at age 40 and older or 10 years younger than the earliest age of diagnosis for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or in two or more first-degree relatives at any age.
- One every 10 years at age 40 and older for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second-degree relatives.

High risk:

- One every year at age 20 to 25, or 10 years younger than the earliest age of diagnosis for individuals with a genetic or clinical diagnosis of hereditary non-polyposis colorectal cancer (HNPCC) or individuals at increased risk for HNPCC.



- One every two years with biopsies for dysplasia for individuals diagnosed with inflammatory bowel disease (IBD), chronic ulcerative colitis (CUC), Crohn's disease, when cancer risk begins to be significant, eight years after the onset of pancolitis, or 10 to 12 years after the onset of left-sided colitis.

Proctosigmoidoscopy or Flexible Sigmoidoscopy

Proctosigmoidoscopy or a flexible sigmoidoscopy for the screening of colorectal cancer is covered in the following circumstances:

Average risk:

- One every three years beginning at age 50.

Increased risk:

- One every five 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 two second-degree relatives diagnosed with colorectal cancer.

High risk:

- Annual flexible sigmoidoscopy beginning at age 10 for individuals with known or suspected familial adenomatous polyposis (FAP).

Other Recommended Colorectal Cancer Screenings

Fecal occult blood test:

- Every 12 months* for all beneficiaries age 50 and older.

*A grace period allows a fecal occult blood test 30 days prior to the anniversary date of the last exam.

Computed Tomographic Colonography

A computed tomographic colonography (CTC) may be a covered benefit for individuals when an optical colonoscopy is medically contraindicated or cannot be completed due to a known colonic lesion, structural abnormality or other technical difficulty is encountered that prevents adequate visualization of the entire colon.

Complications from Non-Covered Services

Complications from non-covered services are only covered when the initial non-covered treatment was provided in a military treatment facility (MTF), authorized

by the MTF Commander and the MTF was unable to provide the necessary treatment for the complication. All other treatment of complications, infection from non-TRICARE covered services or removal of non-covered implants are not a covered benefit.

Compression (Pressure) Stockings

Medical grade compression (pressure) stockings are a covered benefit as **durable medical equipment**. TRICARE covers two pressure stockings per limb per calendar year when medically necessary.

Continuous Positive Airway Pressure (CPAP) Machine

Continuous Positive Airway Pressure (CPAP) machine also known as a respiratory assist device, is considered **durable medical equipment (DME)**. CPAP machines are a limited benefit and may be covered for the following:

- obstructive sleep apnea syndrome or
- respiratory insufficiency

Variable Positive Airway Pressure (VPAP) or Adaptive Servo-Ventilation (ASV) machines, and an Intraoral Pressure Gradient device (also known as a WINX device) are considered unproven and are not covered benefits.

Cord Blood Banking

Umbilical cord blood banking is a limited benefit and only covered when the newborn beneficiary requires a transplant of cord blood. Prior authorization is required.

Cosmetic, Plastic or Reconstructive Surgery

Cosmetic, plastic or reconstructive surgery is a limited benefit. It may be covered to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance after severe disfigurement after cancer surgery, or breast reconstruction after cancer surgery.

Cranial Orthotic Devices or Molding Helmets

Cranial orthotic devices, or molding helmets, 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.

Cranial orthotic devices, or molding helmets, are not a covered benefit for treatment of nonsynostotic positional plagiocephaly or when used alone to treat craniosynostosis. See [alternative resources](#).

Diabetes Self-Management Training

Diabetes self-management training (DSMT) is a limited benefit. This outpatient program educates beneficiaries on the self-management of diabetes.

Outpatient services in this program include:

- education for self-monitoring blood glucose, diet and exercise.
- insulin treatment plans for insulin-dependent beneficiaries.
- a plan to motivate patients to use the skills for self-management.

Initial Training (first year)

DSMT must be ordered by a physician for beneficiaries with diabetes. Services are limited to 10 hours. Additional hours may be covered if the treating physician determines there is a change in medical condition, diagnosis or treatment that requires a change in DSMT.

Follow-Up Training (subsequent years)

Beneficiaries are eligible to receive two hours of follow-up training each calendar year. Training may include a change in DSMT due to a change in medical condition, diagnosis or treatment as determined by the treating physician.

The DSMT program must be accredited by the American Diabetes Association (ADA) or accredited and approved by the Centers for Medicare and Medicaid Services (CMS) to provide DSMT services. (Only HCPCS codes G0108 and G0109 are covered.)

Diabetic Supplies and Equipment

Diabetic Supplies

- insulin products*
- blood and urine glucose test strips
- blood and urine ketone/acetone test strips
- diabetic syringes and needles*
- lancets

These supplies are covered by the **TRICARE pharmacy benefit** and may be obtained from a military treatment facility pharmacy, through **TRICARE Pharmacy Home Delivery** or at any TRICARE retail pharmacy.

*Medicare Part B does not cover insulin (unless used with an insulin pump) and diabetic syringes/needles; the TRICARE pharmacy benefit is the primary payer for these items.

Diabetic Equipment

Diabetic equipment is covered under the TRICARE medical program as **durable medical equipment**:

- home glucose monitors
- continuous glucose monitors are a limited benefit
- insulin infusion pumps are a covered benefit for beneficiaries with:
 - insulin-dependent type 1 diabetes mellitus when there is documentation by the physician of poor diabetic control
 - cystic fibrosis related diabetes
 - type 2 diabetes when there is documentation by the physician of poor diabetic control and the patient has failed to achieve glycemic control after six months of multiple daily injection therapy

See also [Diabetes Outpatient Self-Management Training](#) and [Orthotics](#) for additional diabetic services covered.

For additional information on diabetes education including definitions, symptoms and ways to manage this diagnosis, please visit Health Net's [Diabetes Education](#) page.

Note: Providers requesting diabetic related services or supplies such as a continuous glucose monitor, diabetes self-management training, diabetic shoes, insulin pumps or nail trimming can refer to the [Letter of Attestation](#) page for additional authorization information.

Diagnostic Radiology

The following diagnostic radiology services may be a covered benefit when medically necessary:

- **Breast magnetic resonance imaging (MRI)**. See breast MRI information for limitations.



- **Bone density study (Dexascan).** See bone density study information for limitations.
- Cardiovascular magnetic resonance (CMR).
- Chest X-rays.
- Computerized tomography (CT) scans.
- Helical (spiral) CT scans with or without contrast enhancement.
- Magnetic resonance angiography (MRA).
- Magnetic resonance imaging (MRI) with or without contrast media.
- Mammography to further diagnose breast abnormalities or other problems.
- Open MRI with or without contrast media.
- Portable X-ray services.
- Three-dimensional (3D) rendering.

Dialysis

End Stage Renal Disease (ESRD) services, hemodialysis, and other dialysis services and supplies are covered.

Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies

Some durable medical equipment, **prosthetics**, **orthotics** and medical supplies (DMEPOS) are a limited benefit. TRICARE defines covered DMEPOS as:

- Medically necessary and appropriate for the treatment of an illness, injury, or congenital anomaly(ies) and must improve the function of a malformed, diseased or injured body part, or reduce further deterioration of the patient's physical condition.
- Able to withstand repeated use.
- Primarily and customarily to service a medical purpose rather than for transportation, comfort or convenience.
- Shall be consistent with a beneficiary's symptoms or confirmed diagnosis of illness, injury or congenital anomaly(ies) being treated and not in excess of the beneficiary's needs.

- Ordered by a physician (M.D. or D.O.) for the specific use by the beneficiary. May not be ordered by a podiatrist,* physician assistant or nurse practitioner.
- Wigs, breast pumps and hearing aids are a few of the DMEPOS items that have specific limitations listed on Benefits A to Z on www.hnfs.com.

Duplicate or similar prostheses are not covered unless a beneficiary requires bilateral prostheses. Prosthetic devices for sports-related purposes, exercise equipment, physiotherapy, personal comfort, and convenience are excluded. Some benefit exclusions apply – see "Exclusions" in this section.

*Podiatrists may order prosthetic and orthotic devices and supplies within the scope of their license.

Active duty service members require an approval from Health Net Federal Services, LLC (Health Net) for all DMEPOS items. The TRICARE Management Activity Deputy Director may authorize services, such as orthotics, for active duty service members that are not TRICARE benefits. TRICARE Prime, TRICARE Prime Remote and TRICARE Young Adult Prime beneficiaries require an approval from Health Net for all DMEPOS items with a purchase price greater than or equal to \$2,000, and for any DMEPOS regardless of price from a non-network provider.

All DMEPOS must be ordered by a physician (M.D. or D.O.). It cannot be prescribed by a non-physician (for example, nurse practitioner, physician's assistant or podiatrist). Any DMEPOS with a purchase price of \$150 or greater and all rental items regardless of the price require a certificate of medical necessity (CMN) be submitted with the claim (unless prior authorized). No specific CMN form is required. The CMN should include:

- type of DMEPOS equipment,
- diagnosis/reason DMEPOS is needed,
- length of time the equipment is needed,
- start date/prescribing date, and
- physician name or signature (must be an MD or DO; it may not be a nurse practitioner, physician's assistant or podiatrist). See note below.



Rental

Some DMEPOS are customarily rented due to the cost of the item and/or the length of time the beneficiary requires the item. It is important to note rental costs will not be paid once the total rental allowed amounts reach the TRICARE allowed amount for the purchase price of the item. Once TRICARE has allowed the purchase price, the provider must consider the item purchased and may not continue to bill rental charges.

Active duty service members require an approval from Health Net for all rented DMEPOS items. TRICARE Prime, TRICARE Prime Remote and TRICARE Young Adult Prime beneficiaries require an approval from Health Net for rental DMEPOS when the purchase price is greater than or equal to \$2,000 and for any DMEPOS rental regardless of price from a non-network provider.

- Durable medical equipment that generally exceeds more than \$100 and is not customized for individual beneficiaries is often rented rather than purchased through DMEPOS suppliers.
- The initial DMEPOS rental period is three months. Subsequent rental periods may be in six-month increments for a maximum of 15 months. Rental costs will not be paid after the item has reached the purchase price.

Repairs

Benefits are allowed for repair of beneficiary-owned DMEPOS when it is necessary to make the equipment serviceable. This includes the use of temporary replacement items provided during the period of repair. The DMEPOS provider is responsible for all repairs of rental equipment.

Active duty service members require an approval from Health Net for all DMEPOS repairs. TRICARE Prime, TRICARE Prime Remote and TRICARE Young Adult Prime beneficiaries require an approval from Health Net when the repair price is greater than or equal to \$2,000 and for any DMEPOS repair regardless of price from a non-network provider.

Replacements

Replacement DMEPOS is allowed for beneficiary-owned DMEPOS when the DMEPOS is not serviceable due to normal wear, accidental damage or a change in the beneficiary's condition. Documentation must be submitted

with the claim indicating the reason replacement is required. The DMEPOS provider is responsible for all replacement parts for rental equipment.

See the *TRICARE Reimbursement Methodologies* section of this handbook for more information about DMEPOS reimbursement guidelines.

Education or Counseling Services

Patient and parent education or counseling services are a limited benefit. Most education and training programs are not covered except for limited circumstances under the **Extended Care Health Option (ECHO)** program. The following education or counseling services are covered when included as part of an office visit by a physician or other TRICARE-authorized provider:

- accident and injury prevention
- cancer surveillance
- dental health promotion
- dietary assessment and nutrition
- physical activity and exercise
- safe sexual practices
- stress, bereavement, and suicide risk assessment
- tobacco, alcohol, and substance abuse

Emergency Services and Admissions

Prior authorization is not required for emergency care, however all TRICARE Prime beneficiaries must coordinate all follow-up care with their primary care manager (PCM). If the TRICARE Prime beneficiary is not assigned to a PCM, he or she must coordinate all follow-up care with Health Net. Follow-up care that is not coordinated with the PCM or Health Net may be subject to **point of service (POS) option** cost-shares and deductibles.

TRICARE Standard, TRICARE For Life and beneficiaries with other health insurance do not need to coordinate any follow-up care with Health Net but should notify their family physician of an emergency room visit.

If a beneficiary is admitted, prior authorization may be required. TRICARE providers must notify Health Net of an emergency room inpatient facility admission and discharge date within 24 hours or by the next business day following admission and discharge.



Health Net reviews admission information and authorizes continued care, if necessary. Health Net will conduct continued stay reviews for services listed in the TRICARE North Region **Prior Authorization and Inpatient Notification Requirements Table**. To ensure that MTFs receive timely information regarding care being delivered in civilian hospitals, fax clinical records to the referring MTF's local secure fax number. The **Clearly Legible Reports (CLR) Fax Matrix**, found on the **Clearly Legible Reports** page on the Health Net website, lists each MTF's local secure fax number for providers to use. The CLR Fax Matrix also lists contact information should you have any CLR questions.

The fax number for inpatient admission notification is **1-877-809-8667**. The hospital admission record face sheet should include the beneficiary's demographic information – including sponsor Social Security number, health plan information, name of the admitting physician, admitting diagnosis, and date. If the hospital admission record face sheet is not available, providers can also complete an **Inpatient TRICARE Service Request/ Notification form** and fax it to **1-877-809-8667**. Be sure to note on the form that the information is for an emergency inpatient admission notification.

Note: Per the **TRICARE Reimbursement Manual, Ch. 1, Sec. 28**, network and non-network providers who submit claims for services without obtaining the required prior authorization will receive a 10 percent payment reduction during claims processing. For a network provider, the penalty may be greater than 10 percent depending on whether his or her network contract includes a higher penalty. These payment reduction penalties cannot be passed onto the beneficiary for payment. It is the provider's responsibility to obtain prior authorization when required.

Once Health Net receives the hospital admission record face sheet, a tracking number and an average length of stay goal is issued to the hospital.

Health Net requires direct notification from the hospital at least 24 hours (one business day) prior to discharge, or as soon as the discharge plan and date are established. Once the hospital notifies Health Net about the discharge date and plan, and the beneficiary is discharged, Health Net provides an authorization number which confirms coverage of the inpatient stay from admission to discharge.

If Health Net does not receive the requested clinical information, or if it is determined during the hospital stay

that care is no longer medically necessary, Health Net will issue a denial letter at least 24 hours before the coverage denial goes into effect.

Epidural Steroid Injections

Epidural steroid injections in the cervical, lumbar and sacral (caudal block) regions are a covered benefit.

Eye Examinations

Routine eye exams are a limited benefit under TRICARE and coverage differs by beneficiary category. Routine eye exams may be given by an optometrist or ophthalmologist and may include but are not limited to: refractive services, comprehensive screening for determination of vision on visual acuity, ocular alignment and red reflex, dilation and external examination for ocular abnormalities. The covered CPT® codes for routine eye exams are: 92002, 92004, 92012, 92014, 92015, 99172 and 99173.

The claim should include a routine vision screening diagnosis as the primary diagnosis. Failure to include the routine diagnosis or using an evaluation and management (E&M) procedure code may cause the claim to process as a diagnostic eye exam, which may be subject to authorization and referral requirements. Any claim for a routine eye exam performed beyond the limits defined below will require medical necessity documentation. See *Claims Processing and Billing Information* section of this handbook for specific eye examination billing information.

Active Duty Service Members

TRICARE Prime (excluding TRICARE Prime Remote):

- Eye exams are generally given at a military treatment facility (MTF). An approved referral from Health Net is required for any civilian care.

TRICARE Prime Remote

- TRICARE Prime Remote active duty service members may receive one routine eye exam per calendar year (January 1 through December 31) by a network or non-network ophthalmologist or optometrist without an approved referral.

Active Duty Family Members

TRICARE Prime/TRICARE Prime Remote with an assigned primary care manager (PCM) (including



TRICARE Young Adult Prime):

- One routine eye exam per calendar year (January 1 through December 31) is covered with no copayment.
- No prior authorization or referral is required if given by a network optometrist or ophthalmologist. (If network providers are not available, prior authorization for a non-network provider must be requested through the PCM).

TRICARE Prime Remote without an assigned PCM:

- One routine eye exam per calendar year (January 1 through December 31) by a network or non-network ophthalmologist or optometrist without an approved referral.

TRICARE Standard (including TRICARE Reserve Select and TRICARE Young Adult Standard):

- One routine eye exam per calendar year (January 1 through December 31) is covered. (Applicable cost shares and deductibles apply.)
- No prior authorization or referral is required.

Retirees and Their Family Members

TRICARE Prime (including TRICARE Young Adult Prime):

- One routine eye exam every two years (24-month period) is covered for ages three and older with no copayment. (For example, if the beneficiary had an eye exam on July 15, 2011, his or her next covered exam would be on or after July 15, 2013.)
- For beneficiaries with diabetes, one routine eye exam per calendar year (January 1 through December 31) is covered. The claim should include a routine vision screening diagnosis as the primary diagnosis and a diabetes diagnosis as secondary.
- No prior authorization or referral is required if the service is done by a network optometrist or ophthalmologist. (If network providers are not available, prior authorization for a non-network provider must be requested through the PCM).

Note: The eye exam benefit for beneficiaries recently transitioned from active duty to retired status does not overlap (the clock does not restart upon retirement). If an eye exam was performed while the sponsor was active duty and he or she has since retired, the next covered eye exam will be two years (24-month period) after the last eye exam prior to the sponsor's retirement.

TRICARE Standard (including TRICARE Retired Reserve and TRICARE Young Adult Standard):

- The following requirements/limitations apply to beneficiaries age three through five:
 - One routine eye exam every two years (24-month period) for beneficiaries ages three through five (For example, if a child is three years old and has an eye exam on July 15, 2011 the next covered exam would be on or after July 15, 2013, but before his or her sixth birthday.)
 - No prior authorization or referral is required.



Routine Eye Exams by Beneficiary Category

Figure 4.1

Beneficiary		Coverage	Provider
Active duty service member (ADSM)	TRICARE Prime	As needed to maintain fitness for duty	Military treatment facility, unless specifically referred
	TRICARE Prime Remote (TPR)	One routine eye exam per calendar year (January 1 – December 31)	Network optometrist or ophthalmologist
Active duty family member (ADFM)	TRICARE Prime, and TPR with an assigned PCM	One routine eye exam per calendar year (January 1 – December 31)	Network optometrist or ophthalmologist
	TPR without an assigned PCM	One routine eye exam per calendar year (January 1 – December 31)	Network or non-network optometrist or ophthalmologist
	TRICARE Standard and TRICARE Reserve Select	One routine eye exam per calendar year (January 1 – December 31)	Network or non-network optometrist or ophthalmologist
Retirees and their Families	TRICARE Prime	One routine eye exam every 24 months for ages three and older	Network optometrist or ophthalmologist
	TRICARE Standard and TRICARE Retired Reserve	Routine eye exams are not covered for TRICARE Standard beneficiaries ages six and older. One routine eye exam every 24-month period for beneficiaries ages three through five.	Network or non-network optometrist or ophthalmologist

Non-Routine (Diagnostic) Eye Exams

TRICARE covers diagnostic exams for the treatment of a confirmed or suspected eye condition, such as diabetes or glaucoma. A diagnostic exam may be billed with evaluation and management (E&M) procedure codes such as 992xx, along with the appropriate diagnosis code (other than a routine vision screening diagnosis code) identifying the beneficiary's eye condition. For beneficiaries who require diabetic non-routine eye exams, a diabetes diagnosis could be the primary diagnosis or a secondary diagnosis. Diagnostic exams can be billed with eye exam CPT codes 92002, 92004, 92012, 92014, 92015, 99172, 99173, or the E&M codes.

TRICARE Prime and TRICARE Prime Remote beneficiaries require a primary care manager (PCM) prior authorization and referral from Health Net for all diagnostic eye exams by network or non-network optometrists or ophthalmologists. No prior authorizations or referrals are required for TRICARE Standard beneficiaries.

Vision Screening for Newborns

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

Eyeglasses or Contact Lenses

Active duty service members are covered for eyeglasses at military treatment facilities at no cost. For all other beneficiaries, only the following are covered:

- Contact lenses for infantile glaucoma.
- Corneal or scleral lenses for treatment of keratoconus.
- Scleral lenses to retain moisture when normal tearing is not present or is inadequate.
- Corneal or scleral lenses to reduce corneal irregularities other than astigmatism.



- Contact lenses or eyeglasses for absence or loss of human lens. Replacement contact lenses or eyeglasses are covered when there is a prescription change related to the absence or loss of human lens.

Note: Providers requesting coverage of eyeglasses or contact lenses can refer to the [Letter of Attestation](#) page for additional authorization information.

Additional Information

Additional resources are available for retired service members of all military branches through [Naval Ophthalmic Support and Training Activity \(NOSTRA\)](#).

Flu Vaccine

[Flu vaccines](#) are a covered benefit.

Foot Care

Routine foot care is covered only in very limited circumstances, such as when the patient has a diagnosed systemic medical disease affecting the lower limbs.

See [orthotics](#) for additional benefit information.

Gastric Bypass

See [bariatric surgery](#).

Genetic Testing

Genetic testing is a limited benefit. Tests approved by the U.S. Food and Drug Administration are covered to confirm a clinical diagnosis that is already suspected based on the patient's symptoms and when the results of the test will influence the treatment.

Covered Tests

- chromosome analysis for repeated miscarriages or infertility
- testing for Turner syndrome
- chromosome analysis due to genitalia ambiguity, small size for gestational age, multiple anomalies, or failure to thrive

Note: See [Laboratory Developed Tests \(LDTs\) for more information](#).

Hearing Aids and Hearing Aid Services

Hearing aids, including bone anchored, and hearing aid services are only covered for active duty family members with profound hearing loss. Hearing aids and hearing aid services are not covered for retirees and their family members, TRICARE Reserve Select members and TRICARE Retired Reserve members. See [Alternative Resources](#). TRICARE defines profound hearing loss as follows:

- Adults with a hearing threshold of 40 dB HL or greater in one or both ears when tested at 500, 1,000, 1,500, 2,000, 3,000 or 4,000Hz or 26 dB HL or greater in one or both ears at any three or more of those frequencies or a speech recognition score less than 94 percent.
- Children with a hearing threshold level of 26dB HL or greater in one or both ears when tested in the frequency range at 500, 1,000, 2,000, 3,000 or 4,000Hz.

Hearing Screening

Hearing screenings are only covered for high-risk newborns as defined by the Joint Committee on Infant Hearing, and should be performed before the newborn is discharged from the hospital or within the first three months. Evaluative hearing tests may be performed at other ages during [preventive exams](#).

Heart Monitors

Portable heart monitors, such as a Holter Monitor, are covered when prescribed by a physician as a diagnostic tool for a suspected medical condition. They are generally rented for a couple of days but may be required for a longer period of time depending on the medical need. Personal heart rate monitors used by a beneficiary to track/monitor their own heart activity are not a covered benefit.

Home Health Care

Home health care is covered for skilled nursing care and physical, speech and occupational therapy, for a maximum of 28 hours per week part time or 35 hours per week intermittent.

Care must be provided by a participating home health care agency. The beneficiary must have a plan of care approved by a physician and be confined to the home.



There may be separate charges for **durable medical equipment**, supplies, prosthetics, and specific drugs with applicable copayments and cost shares. Prior authorization is required for all beneficiaries.

Home Infusion Therapy

Home infusion therapy is a limited benefit. Home infusion therapy involves beneficiaries receiving medication (including chemotherapy drugs) in their own home by other than oral means, for example, intramuscularly, subcutaneously, intravenously, or infused through a piece of durable medical equipment. This remains a limited benefit whether the medications are self- or caretaker-administered, or administered by a health care provider.

Prior authorization is required for all beneficiaries except those with other health insurance. The **prior authorization must be received before the initiation of the therapy** in order to ensure medications are received from the correct TRICARE source and any required nursing visits are pre-approved. Services rendered without prior authorization may be ruled as non-covered benefits or may result in a payment penalty. When the provider initially certifies self or caretaker infusion, or injection is medically appropriate for either homebound or non-homebound beneficiaries, the beneficiary must receive education from a home health agency.

Nursing visits will be authorized by Health Net based on the type of services, homebound status of the beneficiary and classification of home health nursing provider. Homebound status for a beneficiary is determined by the provider.

The type of medication and length of administration will determine whether the home infusion/injection medication will be paid under the medical benefit or through the **TRICARE pharmacy** benefit. In general, medications used for home infusion therapy to treat chronic conditions will be paid for under the TRICARE pharmacy benefit. In these instances the TRICARE authorized infusion therapy provider who submits claims for the medication must also be contracted with Express Scripts Inc. Examples of medications infused in the home that are normally paid under the TRICARE Pharmacy benefit include Immune Globulins, Infliximab, Steroids.

The request must be submitted to Health Net for home infusion/injection services. When requesting prior authorization, be sure to include the dose, frequency and route of administration for the medication. Health

Net will generate authorizations as appropriate if the drug is a covered benefit. If covered under the medical benefit, the provider should submit the claim to PGBA. If covered under the TRICARE pharmacy benefit, Health Net will fax an authorization to the TRICARE pharmacy and the provider should submit the claim to the TRICARE pharmacy.

Hormone Replacement Therapy

Hormone replacement therapy may be a covered benefit when used to treat hormone deficiencies, for example, hypothyroidism. Hormone replacement therapy for menopause is a covered benefit for women when used to treat menopausal symptoms or to prevent osteoporosis or other conditions associated with menopause. Most medications are available through **Express Scripts**. Providers should contact Express Scripts to determine approval and availability. Providers who plan to administer injectable specialty drugs not available through Express Scripts may order specialty drugs through a specialty pharmacy (specialty drug supplier) which may require prior authorization if administered in the home. Hormone injections for the treatment of organic impotency are a covered benefit when the medication is approved by the U.S. Food and Drug Administration (FDA) and used for an FDA-approved indication. Growth hormone is a limited benefit.

Hospice Care

Hospice care is a covered benefit. There may be separate charges for durable medical equipment, prosthetics, and specific drugs with applicable copayments and cost-shares. Prior authorization is required for all beneficiaries. Learn more on hospice care within Health Net's **Case Management** program. Some benefit exclusions apply – see "Exclusions" in this section.

Hospitalization for Medical and Surgical Care

Inpatient hospitalization is a covered benefit and includes: semiprivate room (and, when medically necessary, special care units), general nursing, hospital service, inpatient physician and surgical services, meals (including special diets), drugs and medications while an inpatient, operating and recovery room, anesthesia, laboratory tests, X-rays and other radiology services, necessary medical supplies and appliances, and blood



and blood products. See the [prior authorization requirements](#) to determine if approval is required.

Human Papillomavirus (HPV) Deoxyribonucleic Acid (DNA) Testing

HPV DNA testing is a covered benefit for females age 30 and older as a cervical cancer screening when performed with a Pap smear, also known as a Pap test.

Human Papillomavirus (HPV) Vaccine

The human papillomavirus (HPV) vaccine is a limited benefit and may be covered when the beneficiary has not been previously vaccinated or completed the vaccine series.

- Females: The HPV vaccine Gardasil (HPV4) and Cervarix (HPV2) is covered for females ages 9-26. The series of injections must be completed prior to age 27 for coverage under TRICARE.
- Males: Effective December 23, 2011, the HPV vaccine Gardasil (HPV4) is covered for all males ages 9-21 and ages 22-26 who are immunocompromised.

TRICARE Prime, TRICARE Prime Remote for active duty family members and TRICARE Young Adult (TYA) Prime beneficiaries can obtain the HPV vaccination from their primary care manager, a participating retail network pharmacy or any other TRICARE network provider, without a referral.

TRICARE Standard, TRICARE Reserve Select, TRICARE Retired Reserve and TYA Standard beneficiaries can obtain the HPV vaccination from any TRICARE network or non-network provider or pharmacy, without a referral.

Hysterectomy

A hysterectomy is a limited benefit and only covered when medically necessary.

Hysterectomies may be a covered benefit for the following:

- The treatment of pathology (cancer, adenomyosis, fibroids, endometriosis, dysfunctional uterine bleeding)
- The beneficiary is about to undergo or is undergoing tamoxifen therapy
- The beneficiary has been diagnosed with

hereditary non-polyposis colorectal cancer (HNPCC) or found to be a carrier of HNPCC-associated mutations

Immunizations

The TRICARE preventive services benefit includes age-appropriate vaccines (including influenza vaccines) only as recommended and adopted by the Advisory Committee on Immunization Practices (ACIP), accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services, and published in the CDC's [Morbidity and Mortality Weekly Report](#) (MMWR).

Refer to the [CDC's](#) website for a current schedule of recommended vaccines.

Note: Immunizations required for active duty family members (ADFM) whose sponsors have permanent change of station orders to overseas locations are also covered. You must include a copy of the sponsor's change of station orders when filing the claim. TRICARE does not cover immunizations for personal overseas travel.

Meningococcal Disease

The Menactra[®] meningococcal vaccine is a TRICARE-covered benefit for beneficiaries ages two and older.

Menactra[®] is a trademark owned by Sanofi Pasteur Inc. All rights reserved.

Infectious Disease Screening/Prophylaxis

TRICARE covers screening for individuals who have been exposed or are at high risk for several infectious diseases, including hepatitis B and HIV. Pregnant women may be screened for hepatitis B, HIV and rubella antibodies. Beneficiaries at risk for active disease are eligible for screening and/or prophylaxis for tetanus, rabies, hepatitis A and B, meningococcal meningitis, and tuberculosis.

Injection/Infusion Medication

TRICARE covers medications that are approved by the U.S. Food and Drug Administration.

Injection/infusion medications may be administered:

- in the home by self or caregiver.
- in the home by a home health agency.



- in a provider's office.
- in another outpatient setting such as an outpatient hospital or ambulatory infusion center.

For outpatient administration, providers may buy and bill for medication, or obtain it through a specialty pharmacy (specialty drug supplier). Specialty drug suppliers can be located using Health Net's [Network Provider Directory](#).

See Health Net's [home infusion therapy](#) benefit for information on injection/infusion in the home.

Prior authorization is required for home infusion for all beneficiaries. Prior authorization is not required for injection/infusion medication when it is provided in a provider's office or other outpatient setting, unless the beneficiary is an active duty service member.

Intelligence Testing

Intelligence testing is a limited benefit and only covered when medically necessary for the diagnosis or treatment planning of covered psychiatric disorders.

Laboratory Developed Tests

The following laboratory developed tests (LDTs) are a covered benefit under the [Approved Laboratory Developed Tests Demonstration Project](#)*. Some benefit exclusions apply – see "Exclusions" in this section. Prior authorization rules apply as follows:

- BRACAnalysis® (BRCA 1 and BRCA 2) by Myriad Genetic Laboratories Inc. – genetic mutation testing to assess a woman's risk of developing hereditary breast and ovarian cancer
- Oncotype DX® by Genomic Health, Inc. – genetic testing for patients with breast cancer who are considering whether to undergo adjuvant chemotherapy

*The approved LDT Demonstration Project will expire January 26, 2015. BRACAnalysis and its respective marks are trademarks of Myriad Genetic Laboratories, Inc. ©2012 Myriad Genetic Laboratories, Inc. Oncotype DX and its respective marks are trademarks of Genomic Health, Inc. Copyright© 2004 - 2012 Genomic Health, Inc. All rights reserved.

Laboratory and X-ray Services

Laboratory and x-ray services are covered benefits. If these services are performed by the office visit provider on a date different from the office visit or performed by a different provider such as an independent laboratory or radiology facility (even if performed on the same day as

the related office visit) the beneficiary will owe a separate copayment. However, no copayment applies when they are provided as [preventive services](#).

Lactation Counseling

Lactation counseling services are covered when provided during an inpatient maternity stay and are included in the facility's allowed amount.

Lithotripsy

Lithotripsy, also known Extracorporeal Shock Wave Therapy (ESWT), is a covered benefit for the treatment of kidney stones.

Long Term Acute Care

Long-Term Acute Care (LTAC) is a limited benefit covered only in certain circumstances such as when the beneficiary is ventilator-dependent, but has the potential of breathing independently or requires complex wound care. Prior authorization is not required except for active duty service members. However, notification of inpatient facility admissions and discharge dates are required for all TRICARE Prime beneficiaries. See [prior authorization requirements](#) for additional information.

Mammogram

One screening mammogram every 12 months* is covered for women with average risk beginning at age 40. Women with a high risk of breast cancer may receive a screening mammogram beginning at age 30. High-risk indicators include:





- a lifetime risk of breast cancer of 15 percent or greater using standard risk assessment models such as: Gail model, Claus model or Tyrer-Cuzick
- history of breast cancer
- known BRCA1 and BRCA2 gene mutation
- a parent, child or sibling with a BRCA1 or BRCA2 gene mutation and the beneficiary has not had genetic testing for this mutation
- radiation therapy to the chest between 10 and 30 years of age
- history of LiFraumeni, Cowden or Bannayan-Riley-Ruvalcaba syndrome, or a parent, child or sibling with a history of one of these syndromes

Note: See the [Laboratory Developed Tests \(LDTs\)](#) page for BRACAnalysis® coverage.

**A grace period allows a mammogram 30 days prior to the anniversary date of the last exam.*

Mastectomy

A mastectomy, total or partial, is a covered benefit when medically necessary for treatment of breast cancer.

Prophylactic Mastectomy

Bilateral prophylactic mastectomies are a covered benefit for patients with an increased risk of developing breast cancer who have one or more of the following:

- Fibronodular, dense breasts which are mammographically and/or clinically difficult to evaluate and
- Atypical hyperplasia of lobular or ductal origin confirmed on biopsy,
- A history of breast cancer in multiple first-degree relatives* or
- A history of breast or ovarian cancer, also known as Family Cancer Syndrome, in multiple successive generations of family members.*

Unilateral prophylactic mastectomies are covered when the contralateral breast has been diagnosed with cancer for patients with:

- Diffuse microcalcifications in the remaining breast, especially when ductal in-situ cancer has been diagnosed in the contralateral breast,
- Lobular cancer in-situ,

- Large breast and/or ptotic, dense or disproportionately-sized breast that are difficult to evaluate mammographically and clinically,
- In whom observational surveillance is elected for lobular cancer in-situ and the patient develops either invasive lobular or ductal cancer,
- A history of breast cancer in multiple first-degree relatives* or
- A history of breast or ovarian cancer, also known as Family Cancer Syndrome, in multiple successive generations of family members.*

** A positive breast cancer genetic test (BRCA) is not required.*

Mastectomy Bras

Mastectomy bras are a covered benefit as **durable medical equipment**. TRICARE allows two per calendar year.

Maternity Care

TRICARE Prime and TRICARE Prime Remote beneficiaries require a referral from Health Net for civilian professional maternity care services (for example, OB/GYN or nurse midwife). Hospital notification of the inpatient admission and birthing center notification of delivery require notification to Health Net within 24 hours of admission or the next business day.

TRICARE Standard beneficiaries can obtain all maternity care without a prior authorization or referral from Health Net.

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

Covered services include:

- Epidural anesthesia for pain management during delivery
- Medically necessary **maternity ultrasounds**
- TRICARE authorized birthing centers
- Emergency and medically necessary cesarean sections. (Cost-sharing for services and supplies related to elective cesarean sections, those done at the request or convenience of the beneficiary, is limited to what would have been provided for vaginal delivery.)



- Prenatal vitamins that require a prescription
- Home delivery when performed by a TRICARE network or non-network provider including a certified nurse midwife

Be aware of conditions that can lead to **postpartum depression**. Information on surrogacy can be found on Health Net's **Benefits A-Z**.

Maternity Ultrasounds

Maternity ultrasounds are covered separately from the **maternity care** benefit. TRICARE has specific requirements for covering and reimbursing maternity ultrasound services.

Maternity ultrasounds are covered when needed to:

- Estimate gestational age
- Evaluate fetal growth
- Determine chronic maternal diseases (insulin dependent diabetes mellitus), hypertension, systemic lupus, congenital heart disease, chronic renal disease, hyperthyroidism, prior pregnancy with unexplained fetal demise, multiple gestations, post-term pregnancy after 41 weeks, intrauterine growth retardation, oligo- or polyhydramnios, preeclampsia, decreased fetal movement or isoimmunization. These conditions would provide medical necessity to conduct a biophysical evaluation for fetal well-being.
- Evaluate a suspected ectopic pregnancy
- Define the cause of vaginal bleeding
- Diagnose or evaluate multiple births
- Determine heart rate not detectable by Doppler when it should be heard or there is suspicion of fetal demise, making it necessary to confirm cardiac activity
- Evaluate maternal pelvic masses or uterine abnormalities.
- Evaluate suspected hydatidiform mole
- Evaluate the fetus' condition in late registrants for prenatal care

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

For ultrasound coverage updates, visit the Health Net **Maternity Ultrasounds** page.

Medication or Pharmaceuticals

Medication or pharmaceuticals may be covered for those conditions that are approved by the Food and Drug Administration (FDA). Medication or pharmaceuticals for off-label use are not a covered benefit.

Midwife Services

Midwife services provided by a Certified Nurse Midwife (CNM) are a covered benefit. The CNM must be certified by the American Midwifery Certification Board and state licensed when required by the state. Midwife services by a Registered Nurse who is not a CNM may be covered with a physician referral and supervision. See **maternity care**.

Mucus Clearing Devices

Mucus clearing devices may be covered for diseases including, but not limited to, cystic fibrosis, chronic obstructive pulmonary disease, chronic bronchitis, and emphysema. These devices also may also be covered for beneficiaries who have impaired ability to clear secretions.

Nutritional Therapy

Nutritional therapy is a limited benefit and may be a covered when medically necessary and is the primary source of nutrition. Covered nutritional therapies include: enteral, parenteral and oral nutritional therapy. Additionally, intraperitoneal nutrition therapy is only covered for malnutrition as a result of end-stage renal disease. Nutritional therapy may be covered in an inpatient or outpatient setting. Some benefit exclusions apply – see "Exclusions" in this section.

Observation Services

Outpatient observation stays are a covered benefit when a hospital places a patient under observation, but has not admitted him or her as an inpatient. These services generally occur after an emergency room visit or after an outpatient surgical procedure (ambulatory surgery). While outpatient observation stays generally should not exceed 23 hours, up to 48 hours are covered when medically necessary.



Occupational Therapy

Occupational therapy is covered to improve, sustain or restore functions which have been lost or reduced as a result of injury, illness, cognitive impairment, psychosocial dysfunction, mental illness or developmental, learning or physical disability(ies). Occupational therapy must be prescribed and supervised by a physician, certified physician assistant (PA) working under the supervision of a physician or certified nurse practitioner (NP). Coverage is based on the beneficiary's medical needs and generally limited to 24 visits within a 60 day period.

TRICARE Prime and TPR beneficiaries require a Health Net referral for occupational therapy services.

Individualized Education Program (IEP) requirements

Occupational therapy to treat a physical or occupational deficiency due to a cognitive or developmental disorder for beneficiaries ages three to 21 requires physician letter of attestation whenever there is evidence presented to TRICARE that there is an IEP in place for special education services. TRICARE may cover additional occupational therapy when a physician attests that the intensity and/or timeliness of any occupational therapy services offered by the educational agency does not meet the medical needs of the beneficiary.

Office visits, also known as individual provider services, are covered. The following services may be included in an office visit:

- Outpatient office-based medical and surgical care
- Consultation, diagnosis and treatment by a specialist
- Allergy tests and treatment
- Osteopathic manipulation
- Rehabilitation services, for example, physical therapy, speech pathology services and occupational therapy
- Medical supplies used within the office, including casts, dressings and splints

Orthotics

Orthotic devices are a covered benefit. However, benefits for foot orthotics and cranial orthotics are very limited.

Foot Orthotics

Foot orthotics available for individuals with diabetes

For individuals with diabetes, extra-depth shoes with inserts or custom molded shoes with inserts (HCPCS A5500–A5513) are covered. The claim must include a diabetes diagnosis and documentation of one of the following:

- Previous amputation of the foot or part of the foot; or
- History of previous foot ulceration; or
- Pre-ulcerative callus formation, or peripheral neuropathy with a history of callus formation, foot deformity, or poor circulation; or
- The patient is being treated under a comprehensive plan of care for diabetes and needs therapeutic shoes

Documentation needs to be signed by the physician managing the beneficiary's diabetic condition and submitted with the claim.

Coverage of the footwear with inserts for diabetics is limited to one of the following within each calendar year:

- One pair of custom molded shoes (including inserts provided with such shoes) and two pairs of multidensity inserts
- One pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of multidensity inserts.
- Modification of custom-molded or extra-depth shoes may be substituted for one pair of inserts, other than the initial pair of inserts

Orthopedic Braces

Orthopedic braces with shoes are covered if the shoe is an integral part of the brace (neither the shoe nor the brace is usable separately).

Pap Smear

One routine Pap smear, also known as a Pap test, every 12 months* is covered starting at age 18, or younger if sexually active. View **preventive services costs** when performed during a **preventive exam**. There may be costs for a Pap test if performed due to a diagnosis. See cost information for **lab and X-ray services** and **office visits**.

*A grace period allows a Pap test 30 days prior to the anniversary date of the last exam.



Parenting Classes

See [education services](#).

Pediatric Blood Lead Exposure Testing

If a child is at high risk for lead exposure, according to a structured questionnaire developed from the CDC, TRICARE covers a blood lead level screening during each well-child visit from six months of age through six years of age.

Physical Rehabilitation (Acute Inpatient)

Admission for physical rehabilitation is a covered benefit. Prior authorization is not required. However, rehabilitation hospitals are required to notify Health Net of admission within one business day of admission. Clinical information may be requested to extend the initial assigned length of stay. The beneficiary requires a plan of care for treatment and must meet a minimum requirement of three hours of at least two different types of therapy (for example, physical and occupational therapy) per day. This is a separate benefit from [Skilled Nursing Facility \(SNF\) care](#) and [hospitalization](#).

Physical Therapy

Physical therapy is covered to aid in the recovery from disease or injury to help the patient in attaining greater self-sufficiency, mobility, and productivity by improving muscle strength, joint motion, coordination, and endurance.

Coverage is based on the beneficiary's medical needs and generally limited to 24 visits within a 60 day period. Physical therapy must be prescribed and supervised by a physician, certified physician assistant (PA) working under the supervision of a physician or certified nurse practitioner (NP). Physical therapy is covered when rendered and billed by a licensed registered physical therapist or other authorized individual professional provider acting within the scope of his or her license. Some benefit exclusions apply – see "Exclusions" in this section.

Outpatient therapy is authorized based on one visit per day. TRICARE Prime and TPR beneficiaries require a Health Net referral for physical therapy services.

Individualized Education Program Requirements

Physical therapy to treat a physical or occupational deficiency due to a cognitive or developmental disorder for beneficiaries age three to 21 requires a physician letter of attestation whenever there is evidence presented to TRICARE that there is an individualized education program (IEP) in place for special education services. TRICARE may cover additional physical therapy when a physician attests in writing the intensity and/or timeliness of any physical therapy services being offered by the educational agency does not meet the medical needs of the beneficiary.

Physicals

Physicals for Overseas Travel

Physicals for overseas travel are covered for an active duty family member when required to accompany an active duty service member with orders outside the United States and such travel is being performed under orders from a uniformed service. See sponsor's command for assistance.

School Physicals

School enrollment physicals for ages 5-11 years are covered with no frequency limitations.

Positron Emission Tomography (PET) Scan

Positron Emission Tomography (PET) scans are a limited benefit and may be covered for:

- Evaluation of coronary artery disease
- Diagnosis and management of seizure disorders
- The following malignancies: bladder (metastatic), lung, lymphoma, pancreas, follicular, papillary and Hurthle cell thyroid, and recurrent ovarian and colorectal cancer

Preventive Services

Preventive care is a periodic health screening or assessment and is not directly related to a specific illness, injury or set of symptoms. Treatment or monitoring of a medical condition (for example, diabetes, hypertension) is not considered preventive.



Preventive Examinations

TRICARE Standard – A comprehensive preventive exam, which may include a well-woman exam, is covered if it includes or is rendered at the same time as one of the following preventive services:

- a covered immunization,
- Pap smear, also known as Pap test,
- mammogram,
- colon cancer screening or
- prostate cancer screening.

Preventive exam claims usually include a general medical examination diagnosis (V70 or V70.0). A separate diagnosis code for an immunization, screening Pap test, screening mammogram, colon cancer screening or prostate cancer screening is required for claims payment. See the individual services for frequency of coverage.

TRICARE Prime – In addition to the above, TRICARE Prime beneficiaries may receive one comprehensive preventive exam during each of the following age groups without one of the preventive services above. One exam per age group: 2-4, 5-11, 12-17, 18-39 and 40-64. While often rendered by a primary care manager, preventive exams and accompanying immunizations and screenings may be performed by any other network provider without a referral. For coverage of screening Pap tests, mammograms or colonoscopies see the individual services below for frequency of coverage.

Other Preventive Services May Include:

- Colonoscopy, Proctosigmoidoscopy or Flexible Sigmoidoscopy
- Eye Examinations
- Human Papillomavirus (HPV) Deoxyribonucleic Acid (DNA) Testing
- Immunizations/Vaccines
- Human Papillomavirus (HPV) Vaccine
- Zoster (Shingles) Vaccine
- Mammograms
- Pap Smears
- Physicals
- Prostate Cancer Screening
- Skin Cancer Screening
- Well-Child Care (Birth to Six Years)

Prostate Cancer Screening

See [preventive services](#).

Prosthetics

Prosthetics, also known as prosthesis and related supplies are a covered benefit. One prosthetic at a time is covered unless a beneficiary requires bilateral prosthetics. Services to train the beneficiary on the device, repair for normal wear and tear or damage, and customization of the device are a covered benefit.

A replacement prosthetic is covered when needed:

- due to growth; or
- a change in the beneficiary's condition; or
- an item is lost, irreparably damaged or the cost of repair would exceed 60 percent of the cost of replacement.

See also [breast prosthesis](#).

Pulmonary Rehabilitation

Pulmonary rehabilitation services provided as part of a treatment program on an inpatient or outpatient basis may be a covered benefit. The pulmonary rehabilitation services must be proven treatment for the patient's condition. Examples of proven indications are: cardiopulmonary or pulmonary rehabilitation for pre- and post-lung transplant patients, severe Chronic Obstructive Pulmonary Disease (COPD) on an inpatient basis; and moderate and severe COPD on an outpatient basis.

Radiofrequency (RF) Denervation

Radiofrequency (RF) Denervation is a limited benefit. Non-pulsed radiofrequency denervation for the treatment of chronic cervical and lumbar facet pain is a covered, limited benefit when the following specific criteria are met:

- No prior spinal fusion surgery at the vertebral level being treated.
- Low back or neck pain suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations.



- The pain does not radiate to other parts of the body.
- Pain has failed to respond to at least three months of conservative management (e.g., acetaminophen, nonsteroidal anti-inflammatory medications, manipulation, physical therapy or home exercise program).
- A trial of controlled diagnostic medial branch blocks under fluoroscopic guidance has resulted in at least a 50 percent reduction in pain.
- If there has been a prior successful RF denervation, a minimum time of six months has elapsed since prior RF treatment (per side, per anatomical level of the spine).

No prior authorization is required for beneficiaries, however a benefit review is recommended.

Reconstructive Surgery

See [Cosmetic, Plastic or Reconstructive Surgery](#).

Respite Care

Respite care is a limited benefit for eligible active duty service members (ADSMs) and Extended Care Health Option (ECHO) beneficiaries only. Respite care provides needed rest and time off for the primary caregivers who have been caring for the patient at home. ADSMs are limited to a maximum of eight hours per calendar day, five days per calendar week. (View [Respite Care for Injured Service Members](#) for additional information.) The [ECHO Home Health Care \(EHHC\)](#) respite benefit mirrors this benefit, however it is limited to when the caregiver is sleeping. [ECHO](#) respite care is limited to a maximum of 16 hours of care within the same month that another ECHO benefit is authorized and given. Prior authorization is required.

School Physicals

School enrollment physicals for ages 5-11 years are covered with no frequency limitations.

Shoes, Shoe Inserts, Shoe Modifications and Arch Supports

See [orthotics](#).

Skilled Nursing Facility Care

A skilled nursing facility (SNF) admission is covered when both of the following conditions are met:

- The beneficiary has a qualifying hospital stay of three consecutive days or more, not including the hospital discharge day and
- The beneficiary enters the SNF within 30 days of discharge from the hospital.

There is no day limit, as long as medical necessity continues. Coverage includes: a semi-private room, regular nursing services, meals including special diets, physical, occupational and speech therapy, drugs furnished by the facility, and necessary medical supplies and appliances.

Prior authorization is required for active duty service members and Medicare-eligible TRICARE beneficiaries*.

*Prior authorization is required for Medicare-eligible TRICARE beneficiaries on day 101 of the inpatient stay when TRICARE becomes the primary payer. Authorization requests must be submitted to [Wisconsin Physicians Service](#) for approval.

Skin Cancer Screening

Skin cancer screening exams are covered at any age for beneficiaries with family or personal history of skin cancer, increased exposure to sunlight or clinical evidence of precursor lesions.

Sleep Study

Sleep studies are covered under limited circumstances. Sleep studies in a facility or sleep study center are a covered benefit when medically necessary for the following conditions: narcolepsy, Obstructive Sleep Apnea (OSA), impotence or parasomnias (abnormal sleep behavior, such as bruxism, sleepwalking, enuresis and seizure disorder evaluations related to sleep disturbances). Services must be at an authorized facility or sleep study center.

Sleep Study (Home)

Sleep studies in the home are a covered benefit when performed for OSA. Sleep studies in the home are also covered when a diagnosis of OSA has been established, therapy has begun and response to treatment is being evaluated if all of the following requirements are met:



- Ordered, reviewed and interpreted by a physician board-eligible/board-certified in sleep medicine
- The patient has significant symptoms of OSA
- No sleep disorders other than OSA are suspected
- No significant conditions exist that could impact the accuracy of the study (e.g., moderate pulmonary disease, neuromuscular disease, congestive heart failure)
- Use of an FDA-approved Type II or Type III portable monitoring device validated for home environment (Type IV is not covered)

Smoking Cessation Counseling

Smoking cessation counseling is a covered benefit for all TRICARE beneficiaries, except those eligible for Medicare, who live within the United States.

Note: Smoking cessation counseling sessions are not a behavioral health service; however, behavioral health providers may be involved in offering these services.

Two quit attempts in a consecutive 12-month period are covered. A total of 18 counseling sessions may be covered for each quit attempt. This may include a combination of individual and group sessions. However, within the 18 counseling sessions, a maximum of only four individual sessions will be covered. A quit attempt ends 120 days after the first visit during that attempt or after all 18 sessions have been used, whichever comes first. A third quit attempt within the 12-month period may be a covered benefit, however, a physician's order and prior authorization is required.

Counseling sessions must be rendered by a TRICARE-authorized provider practicing within the scope of his or her license or certification. (CPT® codes for individual sessions are 96152, 96153 and 99406, and group session is 99407.)

Speech Therapy

Speech therapy is covered to improve, restore or maintain function, or to minimize or prevent deterioration of function. Speech therapy must be prescribed and supervised by a physician, certified physician assistant (PA) working under the supervision of a physician or certified nurse practitioner (NP). Coverage is based on the beneficiary's medical needs and generally limited to 24 visits within a 60 day period.

TRICARE Prime and TPR beneficiaries require a Health Net referral for speech therapy services.

Individualized Education Program (IEP) Requirements

Speech therapy to treat a speech deficiency due to a cognitive or developmental disorder for beneficiaries' age three to 21 requires a physician letter of attestation whenever there is evidence presented to TRICARE that there is an IEP in place for special education services. TRICARE may cover additional speech therapy when a physician attests in writing that the intensity and/or timeliness of any speech therapy services being offered by the educational agency does not meet the medical needs of the beneficiary.

Surgery (General)

General surgery is a covered benefit when medically necessary and considered proven as part of the treatment plan. Assistant surgeon services are covered in limited circumstances when the services are considered medically necessary and when the complexity of the surgery warrants an assistant surgeon rather than a surgical nurse or other operating room personnel. Prior authorization may apply. Please see the **Prior Authorization, Referral and Benefit Tool** for additional information. See also **ambulatory surgery, cosmetic surgery** or **bariatric surgery**.

Surgical Sterilization

See **birth control**.

Surrogacy

Services and supplies associated with **maternity care**, including antepartum care, childbirth, postpartum care and complications of pregnancy, may be cost-shared when the surrogate mother is a TRICARE beneficiary and has entered into a contractual agreement with the adoptive parents. The contractual agreement will be considered primary coverage. Any undesignated amount, or amount designated for medical expenses under the contract, must be exhausted before TRICARE will cost-share otherwise covered benefits for the TRICARE beneficiary.



Synagis

Synagis®, also known as Palivizumab, is a limited benefit. Synagis is a medication that assists in the prevention of respiratory syncytial virus. Coverage is limited to one dose per month up to a maximum of five consecutive doses for newborns or infants with one of the following:

- Prematurity
- Chronic lung disease
- Congenital heart disease
- Severe immunodeficiency
- Congenital abnormalities of the airway or neuromuscular disease (e.g., cerebral palsy, muscular dystrophy, neurological diseases of the brain and spinal cord like Tay-Sachs disease or spinal muscular atrophy)

See also [injection/infusion medication](#) for additional information.

Transplants

Transplants are a limited benefit. Transplants, excluding corneal transplants, require prior authorization for all beneficiaries. Services and supplies related to a transplant are also covered, including:

- Evaluation of the candidate for transplantation
- Pre- and post-transplant outpatient and inpatient hospital services including medications
- Transportation of the donor organ
- Donor costs*

The following are a few transplants that may be a covered benefit (this list is not all inclusive):

- Corneal transplant (keratoplasty)
- Heart transplant
- Intestinal transplant
- Kidney transplant
- Liver transplant
- Lung transplant
- Pancreas transplant
- Stem cell transplant

Health Net has contracted with facilities that meet specific criteria regarding clinical outcomes, patient-oriented services and evidence-based medicine. These facilities are known as Centers of Excellence (COE). View Health Net's [COE](#) page to determine if a facility near you is a COE for transplantation.

*Donor costs are covered when the donor or recipient is a TRICARE beneficiary. If the donor is not a TRICARE beneficiary, coverage is limited to those services directly related to the transplant procedure itself and do not include any medical care costs related to other treatment of the donor, including complications.

Temporomandibular Joint Syndrome Treatment

Treatment of temporomandibular joint (TMJ) syndrome, occlusal equilibration and restorative occlusal rehabilitation are excluded. Treatment of acute (not chronic) myofascial/TMJ pain may be covered; care of these patients is subject to additional restrictions and 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 four office visits and the construction of an occlusal splint, if necessary to relieve pain and discomfort.
- Treatment beyond four visits, or any repeat episodes of care within a period of six months, must receive individual consideration and be documented by the provider of services.

Urgent Care

Urgent care services are medically necessary services required for illness or injury that would not result in further disability or death if not treated immediately, but does require professional attention within 24 hours. Conditions such as sprains, sore throats and rising temperatures may require urgent care because they have the potential to develop into emergencies if treatment is delayed longer than 24 hours.

TRICARE Prime Plans and Urgent Care

In most cases, TRICARE Prime and TPR beneficiaries can receive urgent care from their PCM by making same-day appointments. If beneficiaries (excluding ADSMs) do not coordinate urgent care with their PCM or Health Net,



care is covered under the **point of service (POS) option**, resulting in higher out-of-pocket costs. If beneficiaries are away from home or need care after hours and cannot wait to see their PCM, they must contact their PCM for a referral, or call Health Net for assistance before receiving urgent care. Urgent care requests are processed for one visit. If additional care is needed, a new approval from Health Net is required.

Ultrasound Imaging

Ultrasounds that are medically necessary are covered. Also see **maternity ultrasounds** for benefit limitations.

Vaccines

Age-appropriate immunizations and vaccines are covered in accordance with **Centers For Disease Control and Prevention (CDC)** age and frequency recommendations. See immunizations.

Varicose Vein Treatment

Varicose vein treatment is a limited benefit. The following services may be covered benefits when used to treat symptomatic varicose veins:

- **compression stockings**
- endoluminal radiofrequency ablation (VNUS procedure)
- endovenous laser ablation
- stab phlebectomy
- transilluminated powered phlebectomy
- sclerotherapy

Vascular Diagnostic Studies, Non-Invasive

Vascular diagnostic studies, non-invasive are a covered benefit except in conjunction with podiatry services.

Ventricular Assist Device

Ventricular assist devices (VAD) are a limited benefit. VADs are used to support heart function and can be external or implantable. These devices may be a covered benefit when the device is approved by the U.S. Food and Drug Administration (FDA) and used for an FDA-approved indication.

Vision Services

Examinations and other services to diagnose or treat a medical condition of the eye, eyelid, lacrimal system, or orbit are covered benefits. A “routine eye examination” is an evaluation of the eyes not related to a medical or surgical condition or injury. See **eye examinations** for additional information.

Well Woman Exam

See **preventive services**.

Well-Child Care (birth to six years)

Well-child care is a covered benefit and includes routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight and head circumference; routine immunizations; and developmental and behavioral appraisal. TRICARE covers well-child care in accordance with the American Academy of Pediatrics guidelines, which recommends exams (with specific screenings) at: newborn, three to five days, by one month, two months, four months, six months, nine months, 12 months, 15 months, 18 months, 24 months, 30 months, three years, four years, five years and six years.

Wigs and Hairpieces

A lifetime maximum of one wig or hairpiece is a covered benefit if hair loss is due to treatment of a malignant disease and the beneficiary has not previously received a wig or hairpiece from another government agency. Wigs with a purchase price of \$150 or greater require a certificate of medical necessity, signed by an M.D. or D.O. The certificate of medical necessity along with the purchase receipt must be submitted with the claim. Wigs and hairpieces for other conditions are not covered. The TRICARE allowable charge per wig is \$2,000.

Shingles (Shingles) Vaccine

The zoster (shingles) vaccine is a TRICARE covered benefit for beneficiaries age 60 and older. Those with chronic medical conditions should discuss any precautions related to this vaccine with their physician.

TRICARE beneficiaries can obtain the shingles vaccine from their family doctor or **participating retail network pharmacy**.



Note: Physicians who do not have the vaccine in stock in their office can order the vaccine as needed through a specialty pharmacy (specialty drug supplier). Specialty drug suppliers can be located using Health Net's [Network Provider Directory](#).

Wheelchairs (Manual)

Manual wheelchairs may be cost-shared when medically necessary. Medically necessary wheelchair accessories may be cost-shared. Examples include: positioning wedges, contour cushions and cushions/surfaces for skin protection.

Exclusions

In general, TRICARE excludes services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder), injury, or for the diagnosis and treatment of pregnancy or well-child care. All services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment, or provided by an unauthorized TRICARE provider, are excluded.

The following specific services are excluded under all circumstances. This list is not all-inclusive. Visit the [TMA Exclusions](#) page for more information.

Items that are not covered, or have limitations, may have alternative health care resources. View Health Net's [Alternative Health Care Resources](#) page for additional information.

- **applied behavior analysis** therapy provided in a group setting
- **abortion**, except when the mother's life is in danger. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided for claims payment.
- **acupuncture**
- **alterations to living spaces**
- **ambulance services** when:
 - vehicles that provide passenger transport to and from medical appointments (for example, medicabs, ambicabs or paratransit)
 - ambulance service used instead of taxi service when the beneficiary's condition would have permitted use of regular private transportation
 - transport or transfer of a beneficiary primarily for the purpose of having the patient closer to home, family, friends or personal physician (with no medical need for the transport)
 - ambulance services related to a condition not covered by TRICARE, such as complications from elective plastic surgery
- **artificial insemination** (including in vitro fertilization, gamete intra-fallopian transfer and all other such reproductive technologies); however, the TRICARE Management Activity Deputy Director may authorize services, such as artificial insemination, for active duty service members that are not TRICARE benefits.
- **assisted living facility**
- **autopsy services or postmortem examinations**
- **aversion therapy**
- **biofeedback** for treatment of psychosomatic conditions and treatment of hypertension
- **biofeedback equipment** (rental or purchase)
- **birth control/contraceptives** (non-prescription)
- **bone density studies** for routine screening of osteoporosis
- **blood pressure monitoring devices**
- **breast implant removal** for autoimmune or connective tissue disorders and for complications resulting from an initial non-covered surgery (for example, elective breast implant).
- **breast MRIs (diagnostic)** for the following:
 - evaluation before biopsy
 - differentiation between benign and malignant breast disease
 - differentiation between cysts and solid lesions
- **breast MRIs (screening)** for women considered to be at low or average risk of developing breast cancer
- **breast pumps** (manual and basic electric)
- **camps** (for example, for weight loss)



- **cardiac rehabilitation programs** (non-hospital based), and Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings.
- **care or supplies furnished or prescribed by an immediate family member**
- **charges that providers may apply to missed or rescheduled appointments**
- **chelation therapy** when used to treat cardiovascular disease, peripheral vascular disease, cancer, chronic fatigue syndrome, Alzheimer's disease, multiple sclerosis, autism, attention deficit hyperactivity disorder, or any other condition for which chelation therapy is not FDA-approved.
- **chronic fatigue syndrome treatment**
- **computerized dynamic posturography**
- **counseling services that are not medically necessary for the treatment of a diagnosed medical condition** (for example, educational, vocational and socioeconomic counseling; stress management; lifestyle modification)
- **clinical trials not sponsored by National Cancer Institute**
- **costs associated with non-treatment research activities related to clinical trials**
- **cranial orthotic device or molding helmet** for treatment of nonsynostotic positional plagiocephaly or for the treatment of craniosynostosis before surgery
- **custodial care**
- **dental care services and dental X-rays** are excluded except authorized adjunctive dental care. See "Adjunctive Dental Care."
- **diagnostic admission**
- **diapers** (incontinence items)
- **dynamic posturography**
- **domiciliary care**
- **dyslexia treatment**
- **elective supplies or services** that are not medically and/or psychologically necessary
- **electrolysis**
- **elevators or chairlifts**
- **endovenous radifrequency ablation** for the treatment of incompetent perforator veins
- **exercise classes** in a swimming pool
- **exercise equipment** (spas, whirlpools, hot tubs, swimming pools, health club memberships, or other such charges or items)
- **experimental or unproven procedures**
- **eye glasses/contact lenses**
 - adjustments, cleaning and repairs for eyeglasses
 - replacement of glasses due to loss, wear or physical growth
 - deluxe or extra features for glasses such as mirror coating, polarization or progressive lenses
 - replenishment of disposable contact lenses, after one initial package is cost-shared, when the prescription remains unchanged
- **food** (food substitutes and nutritional supplements)
- **formulas** (for children less than one year of age) that are readily available in a retail environment and are marketed for use by infants without medical conditions
- **general exercise programs** (even if recommended by a physician and regardless of whether rendered by an authorized provider)
- **gym membership**
- **hair removal**
- **home uterine activity monitoring and related services**
- **hospice care** room and board unless the patient is receiving authorized inpatient or respite level of care
- **hysterectomy** when performed solely for the purpose of sterilization and/or hygiene in the absence of pathology
- **inpatient stays:**
 - for rest or rest cures
 - to control or detain a runaway child whether or not admission is to an authorized institution
 - to perform diagnostic tests, examinations and procedures that could be and are performed routinely on an outpatient basis



- in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care
- **intelligence testing** when used:
 - for academic or vocational placement or assessment,
 - to evaluate non-covered disorders (for example, learning disorders), or
 - to assess intelligence without the need to diagnose or plan treatment for a covered psychiatric disorder
- **laboratory developed tests (LDTs)**, however, some LDTs are a covered benefit under the **Approved Laboratory Developed Tests Demonstration Project**
- **lactation counseling services** billed separately from an inpatient maternity stay
- **laser, pulsed light treatment and sclerotherapy** to treat spider veins
- **laser/LASIK/refractive corneal surgery** except to relieve astigmatism following a corneal transplant
- **learning disability services**
- **lithotripsy** for treatment of plantar fasciitis or other musculoskeletal disorders
- **luxury/convenience equipment or services** such as positioning wedges or pillows, flat free inserts for wheelchair tires and back packs
- **magnetic resonance neurography**
- **manual wheel chair** if TRICARE has already cost-shared a power wheelchair
- **massage therapy**
- **maternity ultrasounds** that are not medically necessary, including three-and-four-dimensional ultrasounds, or determine the sex of the baby
- **maternity services** provided to a TRICARE beneficiary acting as a surrogate without a contractual agreement
- **medications:**
 - drugs prescribed for cosmetic purposes
 - fluoride preparations
 - homeopathic and herbal preparations
 - multivitamins
 - over-the-counter products (except insulin and diabetic supplies)
- **megavitamins and orthomolecular psychiatric therapy**
- **midwife services** by a lay midwife, Certified Professional Midwife (CPM) or Certified Midwife (CM)
- **migraine treatment** services/procedure such as the following:
 - Occipital nerve stimulation
 - Sphenopalatine ganglion block
 - Histamine desensitization therapy
 - Deep brain neurostimulation
 - Cryoablation of the occipital nerve
 - Spinal cord stimulation
 - Trigger point injections
- **mind expansion and elective psychotherapy**
- **National Institutes of Health Clinical Center rendered care**
- **naturopathic care**
- **neurofeedback**
- **nerve blocks for increasing blood supply to the feet and toes**
- **non-medical expenses** such as living expenses outside of the hospital including hotels, meals and transportation of an organ donor
- **non-surgical treatment of obesity or morbid obesity**
- **nutrition and diet counseling**, except when provided under the **diabetes outpatient self-management training**.
- **orthodontia**, such as braces or retainers, is not a covered benefit except when related to the surgical correction of a congenital abnormality such as a cleft palate
- **paternity testing**
- **personal, comfort or convenience items** (such as beauty and barber services, radio, television, and telephone)
- **PET scans** for the following:
 - the following malignancies: bone, gastric, liver, prostate, renal cell, differentiated and medullary cell thyroid, and initial diagnosis of ovarian and colorectal cancer



- the following non-malignancies: stroke, Alzheimer's disease, anorexia nervosa, head trauma, Parkinson's disease, Huntington's chorea, dementia, psychiatric disorders and acute respiratory distress syndrome
- **physical therapy services** performed by a physical therapy assistant
- **physical therapy services for the following:**
 - Diathermy, ultrasound and heat treatments for pulmonary conditions.
 - General exercise programs.
 - Electrical nerve stimulation used in the treatment of upper motor neuron disorders such as multiple sclerosis.
 - Separate charges for instruction of the patient and family in therapy procedures.
 - Repetitive exercise to improve gait, maintain strength and endurance, and assistive walking such as that provided in support of feeble or unstable patients.
 - Range of motion and passive exercises, which are not related to restoration of a specific loss of function
 - Maintenance therapy that does not require a skilled level of assistance.
 - Vocational assessment and training or assessments to determine status of disability.
 - Athletic training evaluation (CPT® 97005 and 97006).
 - CPT 97532 or 97533 when used to improve cognitive function as a result of neuronal growth through the repetitive exercise of neuronal circuits.
 - CPT 97532 or 97533 for sensory integration training.
 - Services provided to address disorders or conditions resulting from occupational deficits.
- **postpartum inpatient stay for a mother to stay with a newborn infant** (usually primarily for the purpose of breastfeeding the infant when the infant, but not the mother, requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother, but not the newborn infant, requires extended postpartum inpatient stay)
- **preventive care** (such as routine, annual or employment-requested physical examinations; routine screening procedures; or immunizations, except as provided under the preventive services benefit; see *Preventive Services* earlier in this section)
- **private hospital rooms** unless ordered for medical reasons or because a semiprivate room is not available. Hospitals that are subject to the TRICARE DRG payment system may provide the beneficiary with a private room, but will receive only the standard DRG amount. The hospital may bill the beneficiary for the extra charges if the beneficiary requests a private room. A **Request for Non-Covered Services form** should be filled out in this case, in advance of providing the non-covered private room.
- **prosthetics** for sports related purposes (if an initial prosthetic was already cost-shared), exercise equipment or physiotherapy are not covered benefits
- **psychiatric treatment for sexual dysfunction**
- **pulsed radiofrequency ablation** for spinal or back pain
- **radiofrequency denervation** for the treatment of thoracic facet pain
- **removal of corns or calluses**
- **retirement homes**
- **routine eye exams** for Standard beneficiaries ages six and older
- **routine foot care** (except if required as a result of a diagnosed, systemic medical disease affecting the lower limbs, such as severe diabetes)
- **safety medical supplies** such as bath or toilet rails, helmets and childproof locks
- **school physicals** for children age four and under, and age 12 and older, including physical exams for college
- **screening diagnostic tests** not related to a specific illness, injury or definitive set of symptoms, except for cancer screening. See **preventive services** for cancer screening information.
- **self-help courses**, except for **diabetes self-management training**
- **sensory integration therapy**



- **services and supplies:**
 - provided under a scientific or medical study, grant or research program
 - for which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor were not TRICARE-eligible
 - furnished without charge (in this case, cannot file claims for services provided free-of-charge)
 - for the treatment of obesity (such as diets, weight-loss counseling, weight-loss medications, wiring of the jaw, or similar procedures; for gastric bypass see *Limitations* earlier in this section)
 - inpatient stays directed or agreed to by a court or other governmental agency (unless medically necessary)
 - occupational disease or injury (for which any benefits are payable under a workers' compensation or similar law, whether such benefits have been applied for or paid, except if benefits provided under these laws are exhausted)
- **services or hospitalizations** as a result of a medical or surgical error
- **services/treatment** related to the terminal illness (other than hospice care)
- **sex changes, or sexual inadequacy treatment with the exception of treatment of ambiguous genitalia that has been documented to be present at birth**
- **shoe inserts, orthopedic shoes** except when attached to a brace, arch supports and other supportive devices for the feet
- **shots administered in a civilian pharmacy**
- **smoking cessation products.** See [smoking cessation counseling](#).
- **speech therapy services for the following:**
 - myofunctional or tongue thrust therapy
 - maintenance therapy that does not require a skilled level of assistance
 - videofluoroscopy evaluation in speech pathology
 - services provided to address disorders or conditions resulting from occupational deficits
- **sports physicals**
- **sterilization reversal surgery**
- **subcutaneous implantable estradiol pellets**
- **subcutaneous mastectomy** for the prevention of breast cancer
- **surgery performed primarily for psychological reasons** (such as psychogenic surgery)
- **telephone counseling/consultation**
- **therapeutic absences from an inpatient facility,** except when such absences are specifically included in a treatment plan approved by TRICARE
- **transplants** if the beneficiary has another existing illness that would jeopardize the success of the transplant or if the transplant is not a proven treatment for the beneficiary's condition
- **transportation except by ambulance**
- **ultrasounds, use** of three-dimensional and four-dimensional rendering and routine screening for breast disease
- **unproven drugs, devices, and medical treatment**
- **vestibular rehabilitation**
- **vision therapy (orthoptics)**
- **weight-reduction** services/programs, sleeve gastrectomy, repeat or revision procedures due to noncompliance with post-operative nutrition and exercise recommendations.
- **wig and hair piece** maintenance, supplies, replacement of the wig or hairpiece, hair transplants or any services or supplies for hair re-growth
- **wisdom teeth removal**

Note: Access a current list of non-covered services at TMA's [No Government Pay Procedure Code List](#) page.



Behavioral Health Care Services



Health Net Federal Services, LLC (Health Net) manages the TRICARE behavioral health care benefit. MHN, a Health Net affiliate company, manages the behavioral health care provider network in the TRICARE North Region. Health Net reviews clinical information to determine if behavioral health care is medically or psychologically necessary. In certain circumstances, TRICARE waives behavioral health care services benefit limits for medically or psychologically necessary services.

Behavioral Health Care Providers

TRICARE covers services delivered by qualified, TRICARE-authorized behavioral health care providers practicing within the scopes of their licenses, to diagnose or treat covered behavioral health disorders. Beneficiaries are encouraged to receive behavioral health care at military treatment facilities (MTFs). However, beneficiaries may be referred to network providers if MTF care is unavailable.

The TRICARE behavioral health care outpatient network consists of TRICARE-authorized providers, such as psychiatrists, psychologists, clinical social workers, certified marriage and family therapists, certified psychiatric nurse specialists, and licensed or certified mental health counselors.* The TRICARE behavioral health care inpatient network consists of hospitals, inpatient psychiatric units, partial hospitalization programs (PHPs), residential treatment centers (RTCs), and substance use disorder rehabilitation facilities (SUDRFs).

* Behavioral health services provided by licensed or certified mental health counselors or pastoral counselors require a physician's documented referral and supervision (a physician is defined as an MD or a DO). Guidelines for participation as a TRICARE-authorized licensed or certified mental health counselor are changing on January 1, 2015. Visit [Health Net's website](#) for detailed guidelines.

Freestanding PHPs, RTCs and SUDRFs must be TRICARE-authorized by the TRICARE Quality Monitoring Contractor, Keystone Peer Review Organization, Inc. (KePRO), and sign participation agreements to comply with all TRICARE policies.

Note: Behavioral health services rendered by a physician assistant (PA) are not covered under TRICARE. Additionally, nurse practitioners may not render behavioral health services under TRICARE unless they are also certified psychiatric nurse specialists.

Prior Authorization and Referral and Requirements

TRICARE prior authorization and referral requirements vary according to beneficiary type, program option, diagnosis, and type of care. General prior authorization and referral requirements are as follows:

Emergency behavioral health care – Emergency care does not require prior authorization. However, if admitted, the facility must contact Health Net within 24 hours of the admission or on the next business day to obtain prior authorization for continued stay.

- **Outpatient behavioral health care for active duty service members** – Active duty service members (ADSMs) should receive behavioral health care at an MTF whenever possible. Active duty service members must have prior authorizations and/or referrals from their PCMs and Health Net before seeking non-emergency behavioral health care.
- **Outpatient behavioral health care for non-active duty service members** – TRICARE Prime and TPR beneficiaries do not need a prior authorization and referral for the initial eight outpatient behavioral health therapy visits to network providers per fiscal year (FY) (October 1–September 30). TRICARE Standard beneficiaries may self-refer to a network or non-network provider for the initial eight outpatient behavioral health therapy visits to network providers per FY. After the initial eight behavioral health outpatient therapy visits, prior authorization is required for all TRICARE beneficiary categories, except TRICARE For Life beneficiaries.
- **Non-emergency inpatient behavioral health care** – For all TRICARE beneficiary categories including ADSMs (except TRICARE For Life beneficiaries), all non-emergency inpatient care requires a prior authorization and referral from Health Net.



Note for TRICARE For Life beneficiaries: TRICARE For Life (TFL) beneficiaries should follow Medicare rules when seeking behavioral health care. If TRICARE is the primary payer (for example, for services Medicare does not cover, if Medicare benefits are exhausted), beneficiaries should follow TRICARE prior authorization and referral requirements as stated for TRICARE Standard beneficiaries above.

Obtaining Referrals and Prior Authorizations

Visit www.hnfs.com to determine current requirements and to submit prior authorization and referral requests for behavioral health care services. Providers who are unable to submit requests online can submit an **Outpatient or Inpatient TRICARE Service Request/Notification Form** via fax (outpatient: **1-888-299-4181** or inpatient: **1-877-809-8667**). To download a form visit www.hnfs.com or call Health Net at **1-877-TRICARE (1-877-874-2273)** to request a form. See the *Health Care Management Administration* section of this handbook for more information about prior authorization and referral requirements.

Note: Per *TRICARE Reimbursement Manual, Ch. 1, Sec. 28*, network and non-network providers, who submit claims for services without obtaining a prior authorization when required, will receive a 10 percent payment reduction during claims processing. For a network provider, the penalty may be greater than 10 percent, depending on whether his or her network contract includes a higher penalty. These payment reduction penalties cannot be passed onto the beneficiary for payment. It is the provider's responsibility to obtain prior authorization when required.

Accessing Behavioral Health Care

TRICARE beneficiaries are encouraged to receive behavioral health care at MTFs whenever possible. However, beneficiaries may be referred to network and non-network providers if MTF care is not available. TRICARE covers services delivered by qualified, TRICARE-authorized behavioral health care providers practicing within the scopes of their licenses, to diagnose or treat covered behavioral health disorders.

Outpatient Services

TRICARE covers medically necessary outpatient behavioral health care services, including outpatient psychotherapy, psychological testing and assessment, medication management, and electroconvulsive therapy.

Outpatient Psychotherapy

TRICARE covers medically necessary outpatient psychotherapy used to treat diagnosed behavioral health disorders. Services must be rendered by qualified, TRICARE-authorized behavioral health care providers practicing within the scopes of their licenses. For information about the requirements for being an authorized TRICARE provider, refer to *TRICARE Policy Manual, Ch. 11*.

The following rules apply:

- A provider cannot bill for more than two sessions per calendar week (Sunday–Saturday) without prior authorization from Health Net.
- When multiple sessions of the same type are conducted on the same day (for example, two individual sessions or two group sessions), only one session is reimbursed.
Note: A collateral session may be conducted on the same day the beneficiary receives individual therapy.
- Two psychotherapy sessions may not be combined to circumvent limits (for example, 30 minutes on one day may not be added to 20 minutes on another day and counted as one session).

The following outpatient psychotherapy coverage limits apply.

- Two sessions per week, in any combination of the following types – refer to the current year CPT® code procedure manual for guidelines on treatment duration:
 - individual (adult or child)
 - family or conjoint
 - group
 - collateral visits (limited benefit)
 - psychoanalysis (limited benefit)



For more information about outpatient psychotherapy, refer to the **TRICARE Policy Manual, Ch. 7, Sec. 3.13**.

CPT Copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Marriage Counseling and Family Therapy

A behavioral health diagnosis must exist for behavioral health benefits to be covered. Since marriage counseling does not indicate the presence of a behavioral health diagnosis, marriage counseling services are **not** covered under TRICARE.

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

Outpatient therapy is limited to a maximum of two sessions per week in any combination of individual, family, group, or collateral sessions. Family therapy is considered covered under the initial eight outpatient behavioral health therapy visits. All visits beyond the initial eight outpatient behavioral health therapy visits require prior authorization from Health Net.

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

Additional resources for marriage counseling and family therapy include:

- Military OneSource – Offers cost-free, confidential counseling sessions to eligible military personnel and their family members. Counseling is available in person or by phone and addresses short-term issues, such as grief and loss, deployment adjustment, work/life management, and combat stress. Visit the **Military OneSource** website or call **1-800-342-9647**.
- Military & Family Life Counselors (MFLCs) – Provide direct, face-to-face, non-medical counseling and education regarding daily life stressors related to deployment and reintegration. The counselors address concerns of stress, relationships, family problems, financial issues, grief and loss, conflict resolution, and the emotional challenges of reintegrating into a non-combat environment. Visit www.mhngs.com for more information.
- Health Net's Online Behavioral Health Resource Center – Designed to help beneficiaries balance work, family and other aspects of life, the Online Behavioral Health Resource Center at www.hnfs.com is available in both English and Spanish, and offers comprehensive articles, information sheets, quick tips, calculators, and more.
- Local military treatment facility – Beneficiaries can check with their local MTFs to see if marriage counseling is a benefit offered through the MTF. Chaplain services are also available at most military bases.
- Community-based services – Beneficiaries can check in their community to see if any city, county or state sponsored behavioral health services, social service agencies, community groups, chaplains or church-based couples/family services are available in the area.

Psychological Testing and Assessment

Psychological and/or neuropsychological testing and assessment are covered only when provided in conjunction with psychotherapy. Psychological testing is limited to six hours per fiscal year (FY) (October 1–September 30), however testing in excess of this limit may be considered for coverage upon review of medical necessity.

Psychological testing is **not** covered for the following circumstances:

- academic placement
- job placement
- child-custody disputes
- general screening in the absence of specific symptoms
- teacher or parental referrals
- diagnosed specific learning disorders or learning disabilities



- Reitan-Indiana battery when administered to a beneficiary under age five and for self-administered tests to a beneficiary under age 13

For more information about psychological testing and assessment, refer to the [TRICARE Policy Manual, Ch. 7, Sec. 3.12](#).

Behavioral Health Medication Management

Behavioral health medication management is a covered benefit when provided as a separate visit. If the provider also provides psychotherapy during the same visit, medication management is included in the TRICARE allowable charge for the psychotherapy. Behavioral health medication management visits do not count toward the initial eight outpatient behavioral health therapy visits or other authorized behavioral health visits and do not require a separate referral. Certified nurse practitioners (NP) within the scope of a state license, may prescribe psychotropic medications as part of an office visit. However, management of these medications beyond the initial prescription must be referred to a qualified behavioral health care provider.

Note: Behavioral health services CPT® codes 99201–99215 are covered under TRICARE. For more information about behavioral health medication management, refer to the [TRICARE Policy Manual, Ch. 7, Sec. 3.15](#).

Electroconvulsive Therapy

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

Inpatient Services

All non-emergency inpatient admissions require prior authorization from Health Net.

Acute Inpatient Psychiatric Care

The beneficiary's age at the time of admission determines coverage limits. Stay limits may be waived if medically or psychologically necessary. The following limits apply:

- beneficiaries age 19 and older: 30 days per FY or in any single admission
- beneficiaries age 18 and under: 45 days per FY or in any single admission

Inpatient admissions for substance use disorder detoxification and rehabilitation count toward the 30- or 45-day limit. Health Net may approve additional days on a case-by-case basis.

Follow-up Behavioral Health Care After Inpatient Stays

The National Committee for Quality Assurance includes outpatient behavioral health follow-up care for patients hospitalized with a psychiatric condition as one of its Healthcare Effectiveness Data and Information Set (HEDIS) measures. Timely follow-up care may help lower rate of re-hospitalization and ease beneficiaries' transitions into their communities. If you are a behavioral health provider contacted by a local hospital or Health Net regarding a beneficiary who is discharging from a psychiatric hospitalization, we ask that you schedule a follow-up appointment with him or her within seven days after discharge. If you are a primary care manager and receive a call from a beneficiary who has recently had a psychiatric inpatient hospitalization, encourage him or her to see a behavioral health care provider within seven days after his or her date of discharge.

Psychiatric Partial Hospitalization Program Care

Psychiatric partial hospitalization programs (PHPs) provide interdisciplinary therapeutic services. Half-day programs must be a minimum of three hours a day and capable of providing services up to five days per week. Full-day programs must be a minimum of six hours a day and capable of providing services up to five days per week. Partial hospitalization programs employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization program care is appropriate for crisis stabilization, treatment of partially stabilized behavioral health disorders or transitioning a beneficiary from an inpatient program when medically necessary.



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

- Acute care hospital-based PHPs – Must be certified by The Joint Commission only.

Freestanding PHPs – Must be certified by KePRO and enter into a participation agreement with TRICARE and obtain required authorization prior to admitting patients. Freestanding PHPs interested in becoming TRICARE authorized should contact **KePRO**.

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

The following coverage limitations apply:

- Partial hospitalization program care is considered elective (non-emergency) and always requires prior authorization from Health Net.
- Partial hospitalization program care is limited to a maximum of 60 treatment days (full- or half-day program) per FY or for any single admission.

Note: Partial hospitalization program care for substance use disorders is limited to 21 days (full- or half-day program) per FY or for any single admission.

- The 60 PHP treatment days are neither offset by, nor counted toward, the 30- or 45-day inpatient limit.

For information about submitting Partial Hospitalization Program claims, see the *TRICARE Reimbursement Methodologies* section of this handbook.

Residential Treatment Center Care

Residential treatment center care provides extended care for children and adolescents with psychological disorders who require continued treatment in a therapeutic environment. The provider must submit documentation with the request, and the behavioral health disorder must meet clinical review criteria before admission can be authorized.

Residential Treatment Center Guidelines

- Residential treatment center care is considered elective (non-emergency) and always requires prior authorization from Health Net.
- Unless therapeutically contraindicated, the family and/or guardian should actively participate in the continuing care of the beneficiary through either direct involvement at the facility or geographically distant family therapy.
- Admission primarily for substance use rehabilitation is not authorized.
- A psychiatrist or clinical psychologist must recommend and direct care.

Coverage limits:

- Care is limited to 150 days per FY or for a single admission.
- Residential treatment center care is only covered for beneficiaries up to age 21.

Note: Health Net may approve additional RTC hours on a case-by-case basis.

TRICARE reimburses RTC care at an all-inclusive per diem rate. The only three charges considered outside the all-inclusive RTC rate are:

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



Substance Use Disorder Services

Treatment for substance use disorders may include outpatient and/or inpatient services, as described below.

Inpatient Detoxification

TRICARE covers emergency and inpatient hospital services for the treatment of the acute phases of substance use withdrawal (detoxification) when the beneficiary's condition requires the personnel and facilities of a hospital. Emergency and inpatient hospital services are considered medically necessary only when the beneficiary's condition is such that the personnel and facilities of a hospital are required.

Coverage limits:

- diagnosis-related group-exempt facility – seven days per episode
- services count toward 30- or 45-day inpatient behavioral health care limit
- services do not count toward 21-day rehabilitation limit

Inpatient Chemical Dependency Rehabilitation

Rehabilitative care may occur in an inpatient or partial hospitalization setting. Care must be provided by TRICARE-authorized facilities. Prior authorization is always required for rehabilitation inpatient stays.

Care is covered for up to 21 days of rehabilitation per benefit period,* including inpatient and partial hospitalization days or a combination of both. TRICARE shares the cost of partial hospitalization rehabilitation treatment for up to 21 days at a predetermined, all-inclusive per diem rate.

Coverage limits:

- one treatment episode per benefit period*
- three treatment episodes during a person's lifetime
- Inpatient stays count toward the 30- or 45-day behavioral health care inpatient limit
- Partial hospitalization rehabilitation treatment counts toward the 60-day psychiatric PHP limit

* A benefit period starts the first day of covered treatment and ends 365 days later.

Outpatient Chemical Dependency Care

Outpatient care must be provided in an individual or group setting by an approved substance use disorder rehabilitation facility (SUDRF), which may either be freestanding or hospital-based.

Coverage limits:

- family therapy – 15 visits per benefit period
- partial hospitalization program care – 21 treatment days

Note: Treatment above these limits may be authorized if more visits are deemed medically or psychologically necessary.

Locating Behavioral Health Providers

Health Net assists all TRICARE beneficiaries with locating TRICARE network behavioral health care providers.

Beneficiaries and providers can call **1-877-TRICARE (1-877-874-2273)** 24 hours a day, 7 days per week, 365 days per year for assistance in locating a behavioral health provider.

Telemental Health Program

Telemental health provides outpatient behavioral health treatment through secure audio and video conferencing via webcam. This benefit is useful when a behavioral health appointment is difficult to get within TRICARE [access standards](#).

Telemental health is a covered benefit for all TRICARE beneficiaries. However, this benefit is not currently available in all geographical areas and is not considered a substitute for face-to-face therapy when available.

To use this service, the beneficiary goes to a scheduled appointment at a TRICARE-authorized provider office that offers telemental health access. The provider's office staff connects the beneficiary with an offsite, TRICARE-authorized behavioral health provider, who provides services such as individual psychotherapy, diagnostic interviews and medication management via webcam. TRICARE does not cover telemental health services provided from a beneficiary's home or any other location not authorized by TRICARE.



Telemental health services are subject to the same requirements, criteria and limitations that apply to medical and psychological services. Telemental health services are considered outpatient psychotherapy visits. Current TRICARE rules regarding behavioral health care (for example, prior authorization and out-of-pocket costs, if applicable) also apply to telemental health services.

Applicable copayments and cost-shares may be higher than a regular behavioral health office visit because both the TRICARE-authorized provider office and the TRICARE-authorized behavioral health provider will charge a copayment or cost-share for services.

Court-Ordered Care

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

Behavioral Health Care and Other Health Insurance

- TRICARE pays after a beneficiary's other health insurance (OHI), including Medicare, employment-based coverage and other insurance policies and plans.
- If the OHI denies a claim because the beneficiary did not follow the OHI's rules, TRICARE also will not pay.
- If services are denied by the beneficiary's OHI on the basis that the care is not medically necessary, TRICARE benefits can only be considered after all avenues of appeal available with the OHI have been pursued.
- Prior authorization is required for inpatient behavioral health services for beneficiaries with OHI.

Non-Covered Behavioral Health Care Services

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

- Aversion therapy (including electric shock and the use of chemicals for alcoholism, except for Antabuse® [disulfiram], which is covered for the treatment of alcoholism)
- Behavioral health care services and supplies related solely to obesity and/or weight reduction
- Bioenergetic therapy
- Biofeedback for psychosomatic conditions
- Carbon dioxide therapy
- Counseling services that are not medically necessary in the treatment of a diagnosed medical condition (e.g., educational counseling, vocational counseling, nutritional counseling, stress management, marital therapy, or lifestyle modifications)
- Custodial nursing care
- Diagnostic admissions
- Educational programs
- Environmental ecological treatments
- Experimental procedures
- Filial therapy
- Guided imagery
- Hemodialysis for schizophrenia
- Intensive outpatient treatment program
- Marathon therapy
- Megavitamin or orthomolecular therapy
- Narcotherapy with LSD
- Primal therapy
- Psychosurgery (surgery for the relief of movement disorder and surgery to interrupt the transmission of pain along sensory pathways are not considered psychosurgery)
- Rolfing
- Sedative action electro stimulation therapy
- Services and supplies that are not medically or psychologically necessary for the diagnosis and treatment of a covered condition



- Services for V-code diagnoses
- Sexual dysfunction therapy
- Surgery performed primarily for psychological reasons (e.g., psychogenic)
- Telephone counseling (except for geographically distant family therapy related to RTC treatment)
- Therapy for developmental disorders, such as dyslexia, developmental mathematics disorders, developmental language disorders, and developmental articulation disorders
- Training analysis
- Transcendental meditation
- Treatment for sexual perpetrators or predators
- Unproven drugs, devices and medical treatments or procedures
- Vagus nerve stimulation therapy
- Z therapy

*Antabuse[®] is a registered trademark of PLIVA HRVATSKA.
All rights reserved.*

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



Health Care Management and Administration

Advance Directives

Hospitals and other health care providers are required under the federal Patient Self-Determination Act to give patients information about their rights to make their own health care decisions, including the right to accept or refuse medical treatment.

The term “advance directive” can describe a variety of documents used to indicate a patient’s requests regarding medical care. Living Will and Health Care Power of Attorney documents are types of advance directives. Some states also have a document specifically called an Advance Health Care Directive. Advance directive may be used to refer to any of these specific documents or all of them in general.

States differ widely on what types of advance directives they officially recognize. Some states also require that patients use a specific form for the format and content of his or her advance directive. Please inform your patients about advance directives and advise them to contact an attorney who is familiar with your state statutes regarding advance directives if they have questions or concerns.

Network Utilization

Military treatment facility (MTF) or TRICARE civilian network providers should be the first option in TRICARE beneficiary care. In most cases, care can be arranged at an MTF or through the civilian provider network while meeting TRICARE **access standards**. TRICARE network and non-network participating providers are expected to refer TRICARE Prime beneficiaries to TRICARE network providers.

If TRICARE Prime and TRICARE Prime Remote (TPR) beneficiaries (excluding active duty service members [ADSMs]) choose to receive TRICARE covered services from a non-network provider without referrals from their primary care managers (PCMs) or Health Net, these services will be covered under the beneficiary’s **point of service (POS) option**.



All TRICARE Prime and TPR requests for a prior authorization or referral to a non-network provider must include specific medical necessity and justification information as to why a non-network provider must be used in lieu of a TRICARE network provider.

The **network provider directory** is located on Health Net’s website.

Referral Process

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

The referral may be either:

- Evaluation only – These referrals are for the initial evaluation of the patient, to include required diagnostic services, but not treatment. This type of referral also includes requests for second opinions.
- Evaluation and treatment – These referrals are for the initial evaluation, required diagnostic services and treatment related to a specific medical condition.

Health Net Referral Requirements by Beneficiary Category

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



All TRICARE Prime and TPR beneficiaries must have a referral from their PCM before seeking care from other professional or individual paramedical providers. In addition to a PCM referral, there are some services Health Net must approve.

Note: Most specialty services for TRICARE Prime and TPR beneficiaries, regardless of where they live, require an approval from Health Net.

Important things to remember about referrals:

- The beneficiary may be directed to receive care at a military treatment facility (MTF). Health Net will confirm if an MTF offers the specialty service being requested and determine its ability to accept the beneficiary for care. If an MTF cannot provide care, Health Net will arrange for services within the civilian network.
- TRICARE Prime and TPR beneficiaries must see TRICARE network providers when available in order to avoid additional costs.
- The **POS option** allows TRICARE Prime and TPR beneficiaries, excluding ADSMs, to self-refer to any TRICARE network or non-network provider for TRICARE covered services without referrals from their PCMs or Health Net. Beneficiaries who use the POS option will pay a deductible and have higher cost-shares for services. For POS cost information, visit [Health Net's website](#).
- Behavioral health services provided by licensed or certified mental health counselors or pastoral counselors require a physician's documented referral and supervision (a physician is defined as an MD or a DO). Guidelines for participation as a TRICARE-authorized licensed or certified mental health counselor are changing as of midnight January 1, 2015. Visit [Health Net's website](#) for detailed guidelines.
- Under the TPR option, the service point of contact (SPOC), PCM and Health Net will coordinate the arrangements for all required military examinations for ADSMs. Civilian PCMs must contact Health Net to initiate the referral process.
 - The SPOC will provide the protocol, procedures and required documentation through Health Net to the provider performing the examination.
 - The SPOC also will review requests for specialty and inpatient care to determine the impact on fitness-for-duty and whether the service member will receive related fitness-for-duty care at an MTF or with a network provider.

Coordinating a Second Opinion

Beneficiaries may contact their PCM or a provider to schedule an appointment for a second opinion. The beneficiary has a right to request a consultation with another provider for a second opinion. Health Net must approve second opinions for TRICARE Prime and TPR beneficiaries.

When approved, second-opinion requests cover the consultation visit, one follow-up visit and diagnostic services (any necessary lab work, X-rays or testing), but not treatment. It will be valid for a specific length of time as stated on the approval letter. Additional services will not be approved by Health Net without an approval from the beneficiary's PCM.

Changing a Provider on a Referral

If a beneficiary was approved to see a network provider and would like to change the approved provider on the referral to a different network provider with the same specialty, the beneficiary does not need to notify Health Net. The current referral is still valid and does not need to be updated. However, if the beneficiary seeks care from the approved provider and then wishes to change to another provider, a new Health Net approval is required.

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

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

Referral Review Guidelines

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



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

- most preventive services (the beneficiary can receive preventive services from other network providers)
- management of minor illness or injury
- minor counseling
- management of stable chronic conditions
- decision making that is straightforward or of low complexity
- encourage the use of the MTF pharmacy or TRICARE Pharmacy Home Delivery

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

Clearly Legible Reports

Network providers must provide clearly legible reports (CLRs), which include specialty care consultation/referral reports, operative reports, notes on the episode of care and discharge summaries to the MTF within seven business days of care delivery. Behavioral health care network providers must submit brief initial assessments within seven business days. The requirement to submit CLRs applies to care referred from an MTF and assists the MTF in meeting The Joint Commission requirements. The reports should contain a patient's identifying information such as first name, middle initial, last name, date of birth, and the last four digits of the sponsor's SSN.

Upon receipt of an approved prior authorization or referral from Health Net, providers will receive a letter that contains a local secure MTF fax number for submitting the CLR to the MTF. Network providers must follow the instructions included with the prior authorization and/or referral from Health Net.

Health Net requires network providers to fax all CLRs directly to the secure fax number for the requesting MTF. The [CLR Fax Matrix](#), found on the [Clearly Legible Reports](#) page on the Health Net website, lists each MTF's secure fax number for providers to use. The CLR Fax Matrix also lists contact information should you have any CLR questions.

Note: The CLR secure fax number should not be used to fax Inpatient or Outpatient TRICARE Service Request/Notification forms for prior authorization and referral requests.

For care referred by a non-MTF (civilian) provider, reports should not be sent to the MTF secure fax number. Follow your normal office protocol and forward non-MTF referred consultation reports to the requesting provider within seven business days of the service or sooner if clinically appropriate. Submission of CLRs to civilian providers is important as it ensures all treating providers are updated on the beneficiary's care.

Urgent and Emergency Care Clearly Legible Report Responsibilities

In urgent and emergency situations, a preliminary report of a specialty consultation should be provided to the referring provider or MTF by telephone or using the MTF's secure fax number within 24 hours of the urgent/emergency care (unless best medical practices dictate less time is required for a preliminary report). Telephonic reports should be followed up with a CLR within seven business days of the urgent/emergent care. MTF individual fax numbers can be found in the [CLR Fax Matrix](#), found on the [Clearly Legible Reports](#) page.

Prior Authorization Process

Prior authorizations are for certain services and/or procedures that require Health Net review and approval, prior to being provided. Some services and/or procedures that require prior authorization include certain behavioral health care, hospitalization, surgical, and therapeutic procedures.

Prior Authorization Requirements

Civilian providers can use the [Prior Authorization, Referral and Benefit Tool](#) to determine if a Health Net prior authorization is required. Prior authorization requirements are subject to change as a result of TRICARE program modifications and/or during annual prior authorization requirement reviews in accordance with Health Net's TRICARE Department of Defense (DoD) contract. Prior authorization requirements are reviewed annually in accordance with Health Net and TRICARE policy to evaluate medical and behavioral health care trends and to better control health care costs for the government.



When requesting a prior authorization, the beneficiary may be directed to receive care at an MTF. Health Net will confirm if an MTF offers the specialty service being requested and determine its ability to accept the beneficiary for care. If an MTF cannot provide care, Health Net will arrange for services within the civilian network.

Per [TRICARE Reimbursement Manual, Ch. 1, Sec. 28](#), network and non-network providers, who submit claims for services without obtaining a prior authorization when required, will receive a 10 percent payment reduction during claims processing. For a network provider, the penalty may be greater than 10 percent depending on whether his or her network contract includes a higher penalty. These payment reduction penalties cannot be passed onto the beneficiary for payment. It is the provider's responsibility to obtain prior authorization when required.

If after visiting our website you are still unsure of prior authorization or referral requirements, submit either an [Outpatient or Inpatient TRICARE Service Request/Notification Form](#) via fax (outpatient: **1-888-299-4181** or inpatient: **1-877-809-8667**) to determine if the service is covered under TRICARE.

When Are Both a Prior Authorization and Referral Required?

Both a prior authorization and a referral are required when a TRICARE Prime or TPR beneficiary receives a referral to a specialist and the specialist wants to perform a service on the prior authorization list. For example, a PCM referral is needed to see a general surgeon, and a prior authorization is needed if the surgeon wants to perform weight loss surgery.

Inpatient Notification Process

Health Net requires notification of all inpatient facility admissions and discharge dates by the next business day following the admission and discharge. Health Net will conduct continued stay reviews for services listed in the TRICARE North Region Prior Authorization Requirement Table located at www.hnfs.com. The medical facility will receive an authorization number after Health Net receives clinical information and discharge date. Clinical records will be requested as necessary. To ensure that the MTFs have insight to care

being delivered in civilian hospitals, clinical records should be faxed to **1-877-809-8667** prior to the beneficiary being discharged.

Letter of Attestation

TRICARE coverage of certain limited benefits is subject to specific clinical criteria. A letter of attestation (LOA) can be submitted by the provider in lieu of additional clinical documentation, when requesting prior authorization for some of these services.

The provider must complete the beneficiary information, provide the diagnosis and medical necessity rationale for the requested services or supplies and then sign the letter to attest to the accuracy of the clinical information.

This letter must then be submitted along with an Outpatient or Inpatient TRICARE Service Request/Notification Form. An LOA is not available for all services. Visit our [Letter of Attestation](#) page for further information and our Provider Forms page to download an [Outpatient or Inpatient TRICARE Service Request/Notification Form](#).

Emergency Admission Prior Authorizations

TRICARE providers must notify Health Net of an emergency room inpatient admission and discharge date within 24 hours, or by the next business day following admission and discharge. Fax the patient's hospital admission record face sheet to Health Net at **1-877-809-8667**. The hospital admission record face sheet should include the beneficiary's demographic information – including sponsor Social Security number, health plan information, name of the admitting physician and admitting diagnosis and date. If the hospital admission record face sheet is not available, providers can also complete an [Inpatient TRICARE Service Request/Notification Form](#) and fax it to **1-877-809-8667**. Be sure to note on the form that the information is for an emergency inpatient admission notification.

Health Net reviews admission information and authorizes continued care, if necessary. Health Net will conduct continued stay reviews for services listed in the TRICARE North Region [Prior Authorization and Inpatient Notification Requirements Table](#). Refer to the *Medical Coverage* section of this handbook for more information on urgent care and emergency services.



Submitting Prior Authorization and Referral Requests

Providers can request a prior authorization or referral from Health Net online, by fax or by telephone.

Providers who have Internet access are encouraged to use the **Online Authorization and Referral Submission Tool** to submit prior authorization and referral requests electronically. Providers can track the status of their prior authorization and referral requests using the Referral and Prior Authorization Status Tool on the **Health Net website**.

Note: Military treatment facility providers should follow MTF procedures for authorizations within the MTF. For care outside of the MTF, providers should coordinate referral prior authorizations and referrals with Health Net based on the specific guidelines established between Health Net and their MTF.

Both civilian and MTF providers should:

- Request services – When services are needed that require a prior authorization or referral from Health Net, the PCM or referring provider must include a written explanation of the services that are being requested to be performed and sufficient clinical information to assist in the treatment of the beneficiary.
- Prepare the beneficiary – The PCM must provide the beneficiary with all the necessary medical records, laboratory results or X-rays, etc., for the beneficiary's appointment. Civilian providers can request a prior authorization from Health Net online, by fax or for care required within 24 hours, by telephone. Civilian providers who have Internet access are encouraged to use the **Online Authorization and Referral Submission Tool**.

Providers are highly encouraged to use the online tool to submit requests, however if needed, providers can fax their request by completing either an **Outpatient or Inpatient TRICARE Service Request/Notification Form** via fax (outpatient: **1-888-299-4181** or inpatient: **1-877-809-8667**). To prevent processing delays, remember these important guidelines when completing the form:

- Be sure to complete every section of the form – including clinical history/previous treatment and supporting test results – for Health Net to process the request in a timely fashion. Health Net will contact the provider's office for further information or clarification if necessary.

- Include the beneficiary's name, sponsor identification number (sponsor's SSN or Department of Defense Benefits Number [DBN]) and a description of the service(s) being requested (including the diagnosis and service codes).
- If completing the form by hand, be sure to write legibly so all letters and numbers are clear.
- If completing the fax form electronically to print and send by mail or fax, you can click and type in each field without having to handwrite the information. You can also download the form to your computer and save the information for future requests.
- Once the form is complete, fax it to **1-877-809-8667** (inpatient) or **1-888-299-4181** (outpatient).
- Do not include a fax cover sheet.
- Fax each patient referral request separately.

Health Net will contact the provider's office for further information or clarification, if necessary, to process the prior authorization or referral request.

If the services meet the required criteria, the beneficiary and the provider will receive a notification letter that lists the specialty provider's name, specialty services, dates and/or visits that are approved. An active prior authorization or referral is one from the PCM or MTF related to the current episode of care less than 180 days old for an active duty service member or less than 365 days old for a non-ADSM. The procedure codes listed on notification letters issued by Health Net are not a guarantee of payment. It is the provider's responsibility to bill the correct procedure code for the actual services rendered.

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

If the request is not approved, the notification letter may include a request for additional information to determine medical necessity:

- For outpatient services, the notification letter will include an authorization number for the approved service(s) or will provide guidance on how to appeal a denied authorization.



- For inpatient services, the notification letter will include a tracking number for the prior authorization request once Health Net is notified of the admission.

Prioritizing Prior Authorization and Referral Requests and Processing Timelines

To prioritize prior authorization and referral requests, network providers should follow the guidelines listed in Figure 6.1. If your office is not equipped with Internet access or a fax machine, you may request a referral from Health Net by calling **1-877-TRICARE (1-877-874-2273)**.

Prioritizing Referral and Prior Authorization Requests

Figure 6.1

<p>When the care is required within 24 hours:</p>	<ul style="list-style-type: none"> • Submit the request online and select Emergent when submitting your request; or • Call Health Net for a telephone referral request at 1-877-TRICARE (1-877-874-2273). • Choose the option for “authorizations and referrals.” • Clearly state that the request is emergent when speaking with the Health Net representative. • Do not fax a request for emergent care.
<p>When the care is required within 72 hours:</p>	<ul style="list-style-type: none"> • Online – Submit the request using the Online Authorization and Referral Submission Tool. • Select “URGENT” when submitting your request; or • By fax – Fax either a completed Outpatient or Inpatient TRICARE Service Request/ Notification Form via fax (outpatient: 1-888-299-4181 or inpatient: 1-877-809-8667) without a cover sheet. • Write the word “URGENT” in large capital letters at the top to identify the need for expedited processing. • Do not phone-in non-emergent requests unless you do not have the Internet or a fax machine.
<p>When requesting a routine prior authorization or referral¹:</p> <p><small>¹Routine referrals relate to care needed within the four-week TRICARE specialty care access standards. Nearly all referral requests are “routine” requests, unless the patient requires care in less than 72 hours.</small></p>	<p>Make the request at least seven days prior to the anticipated date of the service in one of the following ways:</p> <ul style="list-style-type: none"> • Online – Submit the request using the Online Authorization and Referral Submission Tool; or • By fax – Fax either a completed Outpatient or Inpatient TRICARE Service Request/ Notification Form via fax (outpatient: 1-888-299-4181 or inpatient: 1-877-809-8667) without a cover sheet. • Do not phone-in requests unless you do not have the Internet or a fax machine.

¹ Routine prior authorizations or referrals relate to care needed within the four-week TRICARE specialty care access standards. Nearly all prior authorization and referral requests are “routine” requests, unless the patient requires care in less than 72 hours.

Prior Authorization and Referral Processing Timelines

Health Net will process requests in the following timeframes:

- Routine requests are processed within 2–5 business days of receiving the request from the provider.
- Urgent requests are processed in an expedited manner for care that needs to be delivered within 72 hours.
- Requests are processed using the clinical information submitted by the provider. Processing time for both routine and urgent requests may be delayed if sufficient information is not provided.
- Determination letters for routine and urgent requests are faxed directly to the provider.
- Determination letters for routine requests will be delivered to beneficiaries within 7–10 business days after the request has been processed.



Extending Prior Authorization and Referral Requests from Specialists

Specialists can make requests directly to Health Net to extend a prior authorization or referral for an existing episode of care, for example, to request additional visits or change a surgery date.

Note: If a PCM refers a patient specifically for consultation or evaluation only, Health Net will issue a referral for an initial consultation visit and one follow-up visit. These requests cannot be extended.

There must be an “active” or already-approved prior authorization or referral in place for a specialist to request additional visits or services. An active referral is a referral from the primary care manager or military treatment facility related to the current episode of care that is less than 180 days old for an ADSM or less than 365 days old for a non-ADSM.

To request additional visits or services and extend an active prior authorization or referral, specialists must:

- Submit requests to Health Net via the [Online Authorization and Referral Submission Tool](#) or fax an [Outpatient or Inpatient TRICARE Service Request/Notification Form](#) via fax (outpatient: **1-888-299-4181** or inpatient: **1-877-809-8667**) without a cover sheet.
- Provide Health Net with the original prior authorization or referral number assigned to that patient’s initial prior authorization or referral for that episode of care and be sure to note in your request this is a request for additional days or visits as an extension of that episode of care.

Note: For speech, occupational and physical therapies, the specialist must contact the beneficiary’s PCM to obtain a new referral if the original referral to either the therapist or ordering specialty provider has exceeded 180 days for an ADSM or 365 days for a non-ADSM.

Appeals of Prior Authorizations

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

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

According to TRICARE guidelines, an appropriate appealing party is:

- a TRICARE beneficiary (including minors)
- a non-network participating provider
- an appointed representative of an appropriate appealing party
- a custodial parent or guardian of a minor beneficiary is considered the “appointed representative” until the beneficiary reaches 18 years of age (21 years of age for Pennsylvania residents)
 - after coming of age, the beneficiary must submit the appeal on his or her own behalf or appoint a representative (for example, parent) in writing.
- a TRICARE network provider is not an appropriate appealing party; however, the TRICARE network provider may be appointed by an appropriate appealing party to represent him or her in the TRICARE appeal
- an MTF provider or other employee of the United States Government is not a proper appealing party and, due to conflict of interest, may not be appointed as a representative (except a government employee or uniformed services member who represents an immediate family member)
- legally appointed representatives may appeal
- an attorney may submit an appeal if acting on behalf of an appropriate appealing party

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

Note: A network provider cannot submit an authorization appeal unless he or she is appointed as the beneficiary’s representative. See the [Appointment of Representative for an Appeal](#) form.



Denied authorizations which cannot be appealed are:

- authorizations approved under POS
- authorizations redirected and approved to a network provider when a non-network provider was requested
- authorizations redirected and approved to an MTF
- the provider is not TRICARE authorized
- authorizations provided for BRACAnalysis or Oncotype testing under the TRICARE demonstration program

Authorization appeals must be submitted within 90 days of the date on the authorization denial. However, there are additional requirements for expedited appeals as noted below. Providers are encouraged to complete our online appeal form. Appeals with a tracking number can be printed before submittal for your records. If you mail or fax your appeal, be sure to include the following:

- the patient's name, address, phone number, and sponsor's SSN or DBN (required)
- printed name of the person submitting the appeal and the relationship to the patient
- the reason for disputing the denial (required)
- a copy of the initial denial letter and any other documents related to the issue
- additional documents supporting the appeal

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

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

Processing times for appeals are as follows:

Non-Expedited – Processed within 90 days (usually within 30 days)

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

Urgent Expedited – Processed within 72 hours

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

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

- seriously jeopardizing the life or health of the patient or ability to regain maximum function
- subjecting the patient to severe pain which cannot be adequately managed without the requested care

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

Expedited – Processed within three business days

- Expedited appeals are for care that has not been rendered or if the denial is for continued inpatient stay or the patient is not yet discharged.
- The expedited appeal process only applies to care denied as “not medically necessary.”
- Services denied as “not a TRICARE benefit” cannot be processed as expedited.



- The expedited appeal must be filed by the beneficiary or appointed representative of the beneficiary.
- Providers cannot submit an expedited appeal unless he or she is appointed as a representative by the beneficiary.
- Appeals must be postmarked and received within eight calendar days of the date on the denial letter. If postmarked or received after the eighth day, the appeal will be processed as non-expedited.

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

You may submit your request:

Online	Health Net Request for Appeal form
Fax	Health Net confidential fax at 1-888-881-3622
Mail	Health Net Federal Services, LLC TRICARE North Authorization Appeals P.O. Box 105087 Atlanta, GA 30348-5087

Active Duty Service Member Reconsiderations

Under TPR, if an ADSM is notified by his or her PCM, TRICARE-authorized provider, a network provider, Health Net, or the SPOC that a request for services has been denied, an ADSM may have the right to reconsideration. Army, Navy, Air Force, Marine Corps, or Coast Guard ADSMs may direct questions and initiate reconsiderations by calling the Military Medical Support Office (MMSO) at **1-888-647-6676**. If the provider submits the reconsideration on behalf of the service member, the provider must obtain an [Appointing a Representative for an Appeal](#) form signed by the service member.

Providing Care to Beneficiaries from Other Regions and Overseas

Emergency Care

For emergency care, TRICARE never requires prior authorizations or referrals, regardless of where beneficiaries receive care. However, to avoid penalties or denial of a claim, providers must notify the appropriate regional contractor (Health Net for North Region, UnitedHealthcare Military & Veterans for West Region, Humana Military for South Region and International SOS for the TRICARE Overseas Program). TRICARE Prime and TPR beneficiaries are instructed to contact their PCM within 24 hours of an inpatient admission, or the next business day, to coordinate ongoing care.

Note: If the condition that prompted the emergency care is found to be routine and there is no evidence that the condition ever appeared to be anything other than routine, the care will be covered under the POS option for TRICARE Prime and TPR. Exceptions are made if the beneficiary was referred to the emergency department by his or her PCM or regional contractor.





Urgent Care

For urgent care, TRICARE Prime and TPR must receive referrals from their PCMs or regional contractors.

Note:

- If a TRICARE Prime or TPR 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 paying the applicable copayment or cost-share, and you will submit claims to the region in which the beneficiary is enrolled, not the region in which he or she received care.

See the *Claims Processing and Billing Information* section of this handbook for more information.

Prime Travel Benefit Program

The Prime Travel Benefit Program assists TRICARE Prime beneficiaries with expenses incurred for medically necessary non-emergency scheduled specialty care more than 100 miles (one way) from their PCM's office. Visit the [TRICARE Regional Office North website](#) for more information.

Routine Care in Another TRICARE Region

TRICARE beneficiaries are instructed to receive all routine care, when possible, from network providers in their designated regions. However, sometimes 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 and TPR beneficiaries will receive a referral from their PCMs or regional contractors for out-of-region care and will pay applicable cost-shares. Providers will submit claims to the region where the beneficiary is enrolled, not the region in which he or she received care. If a TRICARE Prime or TPR beneficiary does not receive a

referral for out-of-region care, claims will be paid under the POS option. See the *Claims Processing and Billing Information* section of this handbook for more information.

If you have questions about processing claims for beneficiaries from other regions, contact Health Net at **1-877-TRICARE (1-877-874-2273)**.

Caring for TRICARE Overseas Patients in the United States

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

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

While TOP-Prime/TOP-Prime Remote beneficiaries have been educated to contact International SOS to obtain referrals for care when traveling stateside, providers may contact International SOS at **1-877-451-8659** on their patients' behalf.

Claims for all TOP-Prime/TOP-Prime Remote beneficiaries are processed by the Wisconsin Physicians Service (WPS). For more information about TRICARE Overseas, please visit the [TRICARE Overseas website](#).



Medical Records Documentation

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

- Patient identification – Each page of the chart must include a unique identifier, which may include the patient's identification number, medical record number and first and last name.
- Individual records – Each patient must have his or her own record. If information for different family members is kept in the same folder, each patient must have his or her own separate and individual section.
- Personal data – Information must include name, address, date of birth, sex and home, work or contact phone number, as well as emergency contact information. For children, the parent's home or work phone number or any number where parents can be reached is sufficient. For adults, the phone number of a friend or relative, or any number where a contact may be reached and/or a message left is sufficient.
- Allergies – Each record must have an allergy notation in a prominent and consistent place. If a patient has no allergies, this must be noted. "NKDA," "NKA," and "O" are all acceptable notations.
- Chronic/significant problem list – A separate list of all the patient's chronic/significant problems must be maintained. A chronic problem is defined as one that is of long duration, slow progression or shows little change.
- Chronic/continuing medication list – These should be listed on a medication sheet and updated as necessary with dosage changes and the date the change was made. All medications taken on an ongoing basis – both prescribed and over-the-counter – must be noted on the medication list. The drug, dose, route, duration, and quantity of all prescribed medications must be noted. A separate medication sheet is recommended, but a physician may also choose to write out all current medications at each visit. Ongoing medications that have been discontinued since the last visit should be noted on the medication sheet.
- Immunization history – A history of all immunizations must be documented.
- Chart legibility – Charts must be legible to someone other than the writer. A record that is deemed illegible by the reviewer should be evaluated by a second person.
- Informed consent – Physicians must document their instructions to the patient regarding any suggested invasive procedure, making notation of the alternatives to the proposed procedure, any risk involved in the procedures and the patient's understanding and agreement to the planned procedure. An invasive procedure is defined as surgical entry into tissues, cavities or organs, or repair of major traumatic injuries associated with an operating, delivery, emergency room, or outpatient setting, including physician offices.
- Provider signature/name, each entry – An individualized, legible identification of the author, including his or her title, must follow each entry into the medical record, whether the entry is handwritten or dictated.
- Signature on file – A record of the patient's signature (authorizing the physician to treat the patient) must be kept in the medical record.
- Growth chart – The chart is necessary for all patients 14 years of age and under. Entries must be made starting at the initial visit and at all subsequent well-child visits.
- Initial relevant history – There must be evidence that the patient has been questioned on the initial visit regarding serious accidents, past surgeries and illnesses. This may be an initial self-assessment or a History and Physical (H&P) done by the provider.
- Smoking status – Smoking history for patients 12 years and older should be documented somewhere in the record if the patient has been seen by the physician for a physical assessment three or more times.



- Alcohol or substance use/abuse – Alcohol use and/or other chemical substance use for patients 12 years and older should be documented somewhere in the record if the patient has been seen by the physician for a physical assessment three or more times.
 - Date of each visit – Each and every entry must be accompanied by a date (month, day and year).
 - Chief complaint – Each visit to the physician must have a notation specifying the reason for the visit.
 - Physical exam relevant to chief complaint – A notation regarding physical findings in the organ system relevant to the chief complaint should be documented. This includes both normal and abnormal findings and appropriate vital signs.
 - Diagnosis/impression for chief complaint – The diagnosis identified during each visit should be documented.
 - Appropriate use of consultants – If a patient problem occurs that is outside the physician's scope of practice, there must be a referral to an appropriate specialist. If the physician refers a patient to a specialist unnecessarily, this also should be noted.
 - Treatment/therapy plan is documented – Based on the chief complaint, physical exam findings and diagnosis, the treatment plan is clearly documented.
 - Studies ordered appropriately – The studies ordered should be consistent with the treatment plan as related to the working diagnosis at the time of the visit.
 - Results discussed with patient – When diagnostic studies are ordered, the physician should document that the results have been discussed with the patient and any questions have been addressed. If this information is not found, the physician or office staff should be asked what system they have for conveying lab or test results to the patient (for example, cards mailed out for abnormal results).
 - Unresolved problems for previous visits addressed – Documentation should reflect that the physician provides continuous evaluation of problems noted in previous visits.
 - MD review of studies – There must be evidence that the physician has reviewed the results of diagnostic studies. Methods will vary, but often the physician will initial the lab report or mention it in the progress notes.
 - Results of consultations – When the patient is referred to another physician for consultation, there must be a copy of the results of the consult report and any associated diagnostic workup in the chart. Primary physician review of the consultation must be documented. Often the physician initials the consult report. If the PCM needed to take action, this should be documented.
 - Date of next visit – The progress notes for each visit should contain notations as to the specified time frame in which the patient should return (in weeks, months or as necessary).
 - Hospital records – Pertinent inpatient records must be maintained in the office medical records. These records may include, but are not limited to, the following: history and physical, surgical procedure reports, emergency room reports and discharge summaries. For pediatric patients seen since birth by the PCM being audited, the labor and delivery records should be in the chart, including the newborn assessment.
 - Preventive health education – This refers to health teaching provided to the member appropriate for age and lifestyle.
 - Verification of eligibility – It is highly recommended providers retain photocopies of both sides of Common Access Cards (CACs) and identification (ID) cards or a copy of Line of Duty documentation for future reference.
 - HIPAA documentation – Providers are to retain evidence that a Notice of Privacy Practices was presented to any patient and copies of any signed authorization for disclosure or restriction forms.
 - Progress notes specific to beneficiaries receiving approved Extended Care Health Option (ECHO) services – Notes may be requested for review to determine if ECHO services should be allowed, continued or extended.
- Behavioral health records should contain four broad categories of information:



- administrative information related to patient identification
- date of the therapy session
- length of the therapy session
- assessments obtained through examination, testing and observations
- notation of the patient's current clinical status evidenced by the patient's signs and symptoms
- treatment plan
- content of the therapy session
- summary of intervention
- documentation of care
- description of the response to treatment, the outcome of the treatment and the response to significant others
- summary of the patient's degree of progress towards the treatment goals
- discharge plan

Utilization Management

Utilization Management (UM) is a process that manages the beneficiary at the point of care through prospective review, concurrent review, retrospective review, case management, and discharge-planning activities. Health Net will conduct UM, case management and clinical quality management (CQM) activities on care administered outside of the Military Health System.

Prospective Review

Prospective review is the process of reviewing and assessing health care services before they are rendered. Prospective review procedures allow for benefit determination, evaluation of proposed treatment, determination of medical or psychological necessity, assessment of level of care required, assignments of expected length of stay for those types of care, and for facilities not reimbursed on a diagnosis-related group (DRG) basis and appropriate placement prior to the delivery of care. Failure to comply with timeline standards for notification and prior authorization will result in payment reduction.

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

The prospective review program involves review of requested services for:

- appropriate placement prior to delivery of care (that is, appropriateness of setting)
- assessment of level of care required
- assignment of expected length of stay or treatment duration for those types of care and for non-DRG facilities
- benefit determination
- determination of medical or psychological necessity
- evaluation of proposed treatment or services
- identification of potential quality issues
- provider and beneficiary eligibility

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

Initial Inpatient Clinical Review

Health Net's process for initial inpatient clinical review requires hospital providers to submit clinical information to establish the care's medical necessity for those who are admitted to their facilities and who have not received a precertification for services. This typically includes beneficiaries who have been admitted urgently or for emergencies, or who have not received a prior authorization for services.

Inpatient care (both medical/surgical and behavioral health) requires prior authorization for TRICARE Prime and TPR beneficiaries including ADSMs. For TRICARE Standard, TRICARE Reserve Select, TRICARE Retired Reserve, and OHI beneficiaries, only inpatient behavioral health care services require prior authorization.



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

- emergency room documentation
- history and physical
- physician orders
- diagnostic lab results
- diagnostic radiology results
- operative reports
- physician progress notes
- any other documentation that the reviewer considers essential to establish medical necessity

These documents are due to Health Net within 24 hours, or the next business day, of the request.

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

Concurrent Review

Concurrent review is the evaluation of a patient's continued need for treatment and the appropriateness of current and proposed treatment, as well as the setting in which the treatment is being rendered or proposed. Concurrent review applies to all levels of inpatient care and partial hospitalization. If an admission or an extended stay does not meet the required criteria, a request for further review will be sent to the medical director or peer review panel.

When prospective review (prior authorization) is initiated, Health Net will secure the necessary medical information to support the medical, surgical or behavioral health care services. Medical necessity and appropriateness of setting and treatment review is performed by the UM staff with each concurrent review utilizing InterQual® Level of Care Criteria.

A Health Net medical management representative will contact the hospital at the time of admission to obtain initial clinical information and to discuss discharge planning needs. Subsequent contacts are made to discuss goals for length of stay and/or confirm discharge.

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

InterQual Level of Care Criteria is a registered trademark of the McKesson Corp. All rights reserved.

Retrospective Review

The TRICARE Management Activity (TMA) has designated Health Net as the multifunction peer review organization (PRO) for performance of the following retrospective review activities: medical record review (inpatient and outpatient), DRG/coding validation, focused reviews (inpatient and outpatient), and the TRICARE Quality Monitoring Contract manager (TQMC).

Medical records will be reviewed to:

- assess the accuracy of information provided during the prospective review process
- determine the medical or psychological necessity and quality of care provided
- validate the review determinations made by the utilization review staff





- determine whether the diagnostic and procedural information and/or discharge status of the patient as reported on the hospital and/or professional provider's claim matches the attending physician's description of care and services documented in the medical record

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

- Admission review – The medical record must indicate that the inpatient hospital care was medically or psychologically necessary and provided at the appropriate level of care.
- Invasive procedure review – The performance of unnecessary procedures may represent a quality and/or utilization problem. The medical record must support the medical necessity of the procedure performed. Invasive procedures are defined as all surgical and any other procedures that affect DRG assignment.
- Discharge review – Records will be reviewed using appropriate criteria (that is, InterQual) to determine potential problems with questionable discharges, as well as other potential quality problems.
- Home health prospective payment system review – A monthly retrospective review of medical records and claims will be reviewed in accordance with the **TRICARE Reimbursement Manual, Ch. 12, Sec. 8** to evaluate whether services provided were reasonable and necessary, delivered and coded correctly and appropriately documented.
- TRICARE Quality Monitoring Contract – Keystone Peer Review Organization, Inc., (**KePRO**) of Harrisburg, Pa., is the TRICARE Quality Monitoring Contract (TQMC) manager and will assist DoD, Health Affairs, TMA, MTF market managers, and the TROs by providing the government with an independent, impartial evaluation of the care provided to beneficiaries within the Military Health System. The TQMC will review care provided by Health Net network providers in addition to other TRICARE contractors and subcontractors on a limited basis. The TQMC is part of TRICARE's Quality and Utilization Review PRO program, in accordance with 32 CFR 199.15.

- *An Important Message from TRICARE* – TRICARE policy requires that every patient admitted to a hospital receive and sign the **An Important Message from TRICARE** document which details beneficiary rights concerning coverage and payment of his or her hospital stay and post-hospital services. Access this document at the Health Net website. *An Important Message from TRICARE* also discusses the Notice of Non-Coverage typically used by hospitals to inform patients when their health insurance will no longer pay for hospital care. Providers should note, under the rules of the TRICARE Hold Harmless Policy, they cannot bill TRICARE beneficiaries for non-covered services unless the beneficiary agrees in advance and in writing to pay for such services. Therefore, if the beneficiary does not agree to be discharged from the hospital, the provider must have the beneficiary complete a **Request for Non-Covered Services** form. If the beneficiary signs the form within the stated time frames, he or she will be responsible for the charges. Otherwise, the hospital will be responsible for the beneficiary's charges.
- Diagnosis-related group validation – Selected records will be reviewed for focused and intensified reviews to assure that reimbursed services are supported by documentation in the patient's medical record. This review must determine if the diagnostic and procedural information and discharge status of the patient, as reported by the hospital, match the attending physician's description of care and services documented in the patient's record.
- Outlier review – Claims that qualify for additional payment as cost-outliers will be subject to review to ensure costs were medically necessary and appropriate and met all other payment requirements. In addition, claims which qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature or questionable.
- Procedures and services not covered by the DRG-based payment system – ICD-9 and CPT-4 codes will provide the basis for determining whether diagnostic and procedural information is correct and matches the information contained in the medical record.



Case Management Program

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

A nurse, licensed clinical social worker (LCSW) or other health professional, who as the patient advocate, coordinates the beneficiary's health care between the MTF, PCM, specialists, and other health care providers to obtain the best outcome for the beneficiary. They provide cost effective health care, increase beneficiary satisfaction and obtain additional military and community resources based on appropriate needs and availability of the required services.

Conditions which may benefit from case management:

- catastrophic diagnosis (such as head trauma or spinal cord injuries)
- chronic long-term disease
- complex health care needs
- prolonged rehabilitation needs

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

If you have a patient who would benefit from case management, please submit a referral by completing the **Medical (Case) Management Referral** form and either mail or fax it to the Case Management Department. A case manager will contact the beneficiary and his or her physician to discuss individual health care needs.

Authorizations and Referrals

P.O. Box 105423
Atlanta, GA 30348-5423
Fax: **1-888-299-4181**

Visit the Health Net **Case Management** page for more information.

Warrior Care Support Program

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

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

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

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

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

Service members are typically enrolled in the program after being identified through referrals from medical management (for example, UM, Transitional Care, Case Management) or other Health Net associates. Other WCS enrollments may occur through MTF or network provider prior authorizations or referrals.

If you are caring for an ADSM with significant health care challenges, please call **1-877-TRICARE (1-877-874-2273)** to speak with a Health Net representative about WCS.



1:1:1 Program for Unsafe Controlled Medication

TRICARE beneficiaries who may be misusing or abusing controlled medications are identified and referred to the 1:1:1 Program by Express Scripts or Health Net Case Management. Factors taken into consideration include the number of controlled medications the beneficiary uses, the number of physicians prescribing the medications, and the number of different pharmacies filling the prescriptions.

If the beneficiary refuses Case Management or does not respond to the requests for contact, the beneficiary is placed into the 1:1:1 Program. The beneficiary must choose one prescribing provider, one pharmacy, and one hospital to receive medical services and prescriptions for his/her controlled medications.

If the beneficiary designates a prescribing provider, prescriptions for controlled substances written by the designated provider will be processed without further review.

If the beneficiary does not designate a prescribing provider and a hospital, or seeks services from someone other than his/her designated provider or hospital for his/her controlled medications, his/her claims for certain health care services may be denied and he/she will be responsible for 100 percent of pharmacy costs for all controlled medications.

Discharge Planning

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

Transitional Care Program

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

time of discharge from acute care to home.

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

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

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

Policy on Separation of Medical Decisions and Financial Concerns

Health Net has a strict policy:

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

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



Clinical Quality Management

Health Net is committed to providing the highest quality health care possible to TRICARE beneficiaries by partnering with TRICARE providers who share this goal. In compliance with DoD requirements, Health Net has a CQM program for assessing and monitoring care and services rendered to TRICARE beneficiaries throughout the health care delivery system.

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

- ensure the interventions are implemented and remain effective
- conduct studies and/or quality improvement projects on HEDIS measures or U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators
- use administrative data monitors to enable a more comprehensive view of PQIs and patient safety issues
- expand our provider and beneficiary educational initiatives

The program achieves this by reviewing potential quality issues/patient safety issues, resolving beneficiary and provider grievances and performing clinical quality review studies. Peer review and compliance with professionally recognized standards form the basis of the potential quality issues/patient safety investigation process. Periodic reassessments assure that improvements remain effective.

Corrective action may include, but is not limited to:

- provider notification (by oral or written contact) and education (for example, through required further training)
- provider recertification for procedures or services or in-service training for staff
- submission of a corrective action plan for review and follow-up monitoring

- administrative policies and procedure revision as appropriate
- prospective or retrospective trend analysis of practice patterns
- intensified review of practitioners or facilities, including, but not limited to, requirements for second opinions for procedures, retrospective or prospective review of medical records, claims, or requests for prior authorization
- modification, suspension, restriction, or termination of participation privileges

Credentialing and Certification

Health Net conducts an initial credentials review on each potential network provider to determine if the provider meets the minimum criteria. All providers who wish to contract with Health Net are required to complete an application form and participate in an extensive review of qualifications, education, licensure, malpractice coverage, etc. Health Net retains the right to deny or terminate any provider who does not meet or no longer meets Health Net, TRICARE or URAC standards.

Additionally, Health Net conducts a full re-credentialing review of health care providers every three years to help maintain current, accurate files and to ensure all providers meet credentialing requirements. As a TRICARE network provider, you are required to re-credential which includes updating qualifications, education, licensure, malpractice coverage, adverse actions, etc.

There may be times between credentialing cycles when it is appropriate to add, change or delete a specialty description as represented in the provider directory. To make this change, you may need additional education or training documentation if it was not verified or requested during the previous credentialing process. Please select the option for “contracting and credentialing” at **1-877-TRICARE (1-877-874-2273)** for the appropriate forms, information and instructions.

Note: Behavioral health providers should call MHN at **1-800-541-3353** for questions about joining the behavioral health TRICARE network and the MHN credentialing process.



Health Net Conditions of Participation for Network Providers

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

- have a signed Medicare CMS-460 Agreement or participate with Medicare on a claim-by-claim basis for eligible Medicare beneficiaries
- provide an SSN for all claims processing; an Employer Identification Number (EIN) may be provided, if group only, but additional information will need to be collected for the required individual criminal background history checks
- provide a Network Provider Identifier (NPI) for all individuals (Type I) and entities (Type II) billing with your organization
- provide a service that is a covered benefit to the plan member
- agree to conditions of participation per the network agreement
- maintain professional liability coverage in accordance with your provider agreement, but generally the limits are at least \$200,000 per occurrence and \$600,000 aggregate
- all physicians have active hospital privileges, in good standing, at a Joint Commission or Healthcare Facilities Accreditation Program (HFAP)-accredited facility or Det Norske Veritas (DNV) - accredited facility (May be waived under specific conditions)
- have a current, valid, unrestricted DEA certificate or State Controlled Substance certificate, if applicable
- have completed education and training appropriate to application specialty(ies)
- have no unexplained gaps in work history for the most recent five years
- have malpractice history not excessive for area and specialty
- have no felony convictions
- have no current Medicare or Medicaid sanctions
- have no current disciplinary actions (including, but not limited to, licensure and hospital privileges)

- sign and include an unmodified “Credentials Attestation, Authorization and Release”
- provide supporting documentation for all confidential questions on the application (No patient names, please.)

Additional Requirements Exclusively for Primary Care Managers

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

Delegated Credentials/Subcontracted Provider Functions

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

- credentialing plan and policies and procedures meet Health Net’s reasonable standards, guidelines, and any required national accrediting standards
- comply with Health Net’s credentialing criteria (credentialing standards)
- comply with applicable state and federal regulations (including compliance with applicable Medicare laws, regulations and CMS instructions)
- be properly credentialed and re-credentialed before rendering covered services to beneficiaries (includes current and future professional providers)
- notify Health Net in writing of all new professional providers who become affiliated with and are credentialed by him or her
- cooperate with Health Net’s timelines and schedules related to the production of accurate provider directories
- maintain all records necessary for Health Net to monitor the effectiveness of network provider’s credentialing and re-credentialing process,



including, but not limited to, records related to the credentialing of all current or future professional providers (professional provider records)

- annually, or upon reasonable request, provide Health Net with credentialing policies and procedures for review and evaluation; and permit and cooperate with Health Net's review of records
- submit credentialing and re-credentialing reports that identify those professional providers credentialed/re-credentialed, the effective date of such actions, the most recent prior date of credentialing/re-credentialing, and the effective date of such professional provider's participation
- notify Health Net of any material change in performing delegated functions
 - Upon written notice, Health Net has the right to revoke and assume the delegated functions and responsibilities if Health Net determines the provider either does not or will not have the capacity, ability or willingness to effectively perform, or is not effectively performing the delegated function.
- sub-delegation of any delegated functions to another organization requires that the provider request Health Net's prior approval in a written request
 - No sub-delegation may occur prior to Health Net's review and written approval. At Health Net's sole discretion, it may approve or deny any requested sub-delegation. If Health Net approves any sub-delegate, then any sub-delegated function remains subject to the terms of the delegation agreement between the provider and Health Net. Health Net retains ultimate oversight of any functions of the sub-delegate.

Health Net retains the right to:

- approve new professional providers and sites, and to terminate or suspend individual professional provider contracts
- approve or deny any provider or site seeking to participate with Health Net
- audit performance of delegated functions at any time and at least every three years
 - audit as frequently as necessary to assess performance and quality

- revoke and assume the functions and responsibilities delegated to the provider if the provider fails to comply or correct any delegated functions within a specified period identified by Health Net in a written notice

Fraud and Abuse

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

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

Health Net's Program Integrity Department is dedicated to combating specifically health care fraud and abuse committed against the TRICARE program. It is also required that all Health Net associates are trained and responsible for reporting any potential or actual fraud and abuse incidents.

Each report of potential fraud or abuse goes through an exhaustive review process. Cases in which there is clear evidence of intent to defraud or serious issues concerning quality of patient care are referred to the government for further investigation and possible prosecution.

To minimize the possibility of a fraud or abuse incident, Health Net:

- has a dedicated Program Integrity Department and a Special Investigations Unit
- implements state of the art fraud detection software
- requires all Health Net associates complete fraud and abuse training
- follows reporting procedures required by the government

Some examples of fraud include:

- 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, necessary or at a higher level to the beneficiary
- billing the claim for an MD when a physician assistant or nurse practitioner delivered services



- duplicate billings (for example, 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, 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 in any state or U.S. territory will result in a loss of authorized-provider status under TRICARE
- reciprocal billing (that is, billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed)
- violating the participation agreement, resulting in the beneficiary being billed for amounts that exceed the TRICARE allowable charge or cost
- falsifying eligibility

Examples of abuse include:

- pattern of waiving cost-share/deductible
- failure to maintain adequate medical or financial records
- pattern of claims for services not medically necessary
- refusal to furnish or allow access to medical records
- improper billing practices

Providers are cautioned that unbundling, fragmenting, or code gaming to manipulate the CPT codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such practices 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 works in conjunction with the Program Integrity Branch to deal with fraud and

abuse. The DoD Inspector General and other agencies investigate TRICARE fraud.

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

- who committed the fraud
- when the fraud occurred (time frame)
- where the fraud occurred
- detailed description of the fraudulent activity

Providers can report an incident or learn more about fraud and abuse through one of four resources:

Phone	TRICARE Fraud and Abuse Hotline 1-800-977-6761
E-mail	Program.Integrity@healthnet.com
Online	www.hnfs.com
Mail	Health Net Federal Services, LLC ATTN: Program Integrity P.O. Box 105310 Atlanta, GA 30348-5310

Grievances

A grievance is a written complaint or concern about a medical provider, Health Net or the TRICARE program in general. Appeals and claim review issues are separate from grievances.

The Health Net grievance process allows full opportunity for any TRICARE beneficiary, beneficiary's representative, network or non-network civilian or military provider to report in writing any concern or complaint (grievance) regarding health care quality or service.

Grievances are generally resolved within 60 days of receipt. Following resolution of a grievance, the grievant/aggrieved party will be notified of the review completion.

Grievance Issues

Issues may include, but are not limited to:

- quality of health care or service aspects, such as: accessibility, appropriateness, level and continuity of care, timeliness, effectiveness, and outcome



- demeanor or behavior of providers and their staffs
- performance, level of courtesy, lack of professional behavior, or any part of the health care delivery system, including Health Net associates
- practices related to patient safety
- Health Insurance Portability and Accountability Act (HIPAA) violations
- delays in processing prior authorizations and referrals

Required Information for Grievances

Beneficiary-submitted grievances must include:

- beneficiary's name, address and telephone number (include area code)
- sponsor's personal identification number (sponsor's SSN)
- beneficiary's date of birth
- beneficiary's signature

A description of the issue or concern must include:

- date and time of the event
- name of the provider(s) and/or person(s) involved
- location of the event (address)
- nature of the concern or complaint
- details describing the event or issue
- appropriate supporting documents

Additional information may be required when submitted by someone other than the involved beneficiary.

The involved beneficiary or representative may submit the **TRICARE North – Health Net Grievance** form online, by mail or fax. However, if a representative is submitting a grievance, the **Authorization for Disclosure** form must be printed, completed, signed, and returned by mail or fax.

Submit a TRICARE North – Health Net Grievance form or a letter outlining the grievance information previously listed in one of the following ways (online submission of the Authorization for Disclosure form is not permitted and must be sent by mail or fax):

Fax	1-888-317-6155
Mail	Health Net Federal Services, LLC ATTN: Grievances P.O. Box 105338 Atlanta, GA 30348-5338
Online	www.hnfs.com





Claims Processing and Billing Information



North Region Claims Processor

PGBA, LLC

PGBA, LLC (PGBA) is Health Net Federal Services, LLC's (Health Net's) partner for claims processing in the TRICARE North Region. The **Health Net** and **PGBA** websites offer many online claims customer service features, including eligibility, claim status and electronic claims submission.

TRICARE network providers must file TRICARE claims electronically with Health Net/PGBA, even when a patient has other health insurance (OHI). Wisconsin Physicians Service (WPS) is the claims processor for all TRICARE For Life (TFL) claims. Claims for certain home infused or injected medications will be processed by Express Scripts Inc. but must first be coordinated through Health Net.

Non-network providers are encouraged to take advantage of the electronic claims and electronic funds transfer (EFT) features available through Health Net and PGBA. For more information, visit the **Health Net** and **PGBA** websites.

Claims Processing Standards and Guidelines

The following information provides guidelines for processing claims in the North Region.

- TRICARE network providers must file all claims electronically (see "Electronic Claim Submission" later in this section) within 90 days of the date of service.
- Where TRICARE is the secondary payer, the 90 days will commence once the primary payer has made payment or denied the claim.

HIPAA National Provider Identifier Compliance

TRICARE requires electronic claims be filed using the appropriate HIPAA-compliant and standard electronic claims format. If a non-network provider must submit paper claims, TRICARE requires use of either a CMS-1500 (professional charges) or a UB-04 (institutional charges) claim form.

All covered entities must use their National Provider Identifiers (NPIs) on HIPAA standard electronic transactions in accordance with the HIPAA Transaction Electronic Data Interchange (EDI) for Health Care Providers Implementation Guide. When filing claims with NPI(s), billing NPIs are always required. When applicable, rendering provider NPIs are also required. Providers treating TRICARE beneficiaries referred by another provider should also obtain the referring provider's NPI and include it on transactions, if available. See the *Important Provider Information* section of this handbook for additional details on HIPAA NPI compliance.

Important Billing Tips

There are several reasons why claims are delayed or denied unnecessarily. The following are some helpful billing tips to help facilitate prompt claim payments. Many of these tips are based on paper claims submissions, however you can find specific electronic claims billing tips on **PGBA's** website.

- Active duty service member (ADSM) claims – Send **TRICARE Prime Remote** (TPR) and **Supplemental Health Care Program** (SHCP) claims to PGBA for processing and payment. There are no copayments, cost-shares or deductibles for ADSMs.



Note: Active duty service member claims will be paid at the same negotiated rate as stated in the provider agreement. The same balance billing limitations applicable to TRICARE apply to the SHCP. For more information regarding balance billing, see the *Important Provider Information* section of this handbook.

- **Additional prior authorization** – If you render additional services beyond what has been covered by the initial prior authorization, you must notify Health Net to extend authorization and ensure correct claims payment.
- **Admitting diagnosis** – The admitting diagnosis is required on all UB-04 inpatient claims.
- **Anesthesia claims** – Claim submissions must include the five-digit CPT®-4 anesthesia code, start and stop times and the appropriate anesthesia modifier. Claims submitted with surgical codes will be denied.

CPT copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

- **Beneficiary signature** – Include the TRICARE beneficiary's signature in Boxes 12 and 13 of the CMS-1500 claim form. You may indicate "patient not present" if the beneficiary's signature is on file. For laboratory and X-ray services, you may indicate "patient not present for services." Also include the TRICARE sponsor's Social Security number (SSN) in Box 1 of the CMS-1500 claim form or FL 60 of the UB-04 claim form.
- **Claims status** – You can check the status of submitted claims online on **Health Net's** or **PGBA's** website, or by calling **1-877-TRICARE (1-877-874-2273)** and accessing the interactive voice response (IVR) system.
- **Claims questions** – You can submit secure electronic mail questions regarding your claims using AskUs through myTRICARE.com.
- **Clean claims** – Most clean claims (claims that comply with billing guidelines and requirements, have no defects or improprieties, include substantiating documentation when applicable, and do not require special processing that would prevent timely payment) will be processed within 30 days. Generally, claims aged more than 30 days will be paid interest in addition to the payable amount.

- **Demographic changes** – You must inform Health Net if any changes occur in professional affiliation, TIN, office location, telephone number and general or prior authorization/referral fax number. Use the **Provider Demographic Updates form** or call **1-877-TRICARE (1-877-874-2273)** to update your information. Additionally, Health Net will contact network providers periodically to verify provider demographic information, if they are accepting new patients and their ability to meet office appointment and access standards.
- **Dual-eligible beneficiaries for Medicare and TRICARE for Life** – Claims for dual-eligible beneficiaries must be submitted to Medicare first. Claims will automatically be transmitted from Medicare to TRICARE for secondary claims processing, and Wisconsin Physicians Service (WPS) will process the TRICARE portion of the claim. Refer to "Claims for Beneficiaries Using Medicare and TRICARE" later in this section for more information.
- **ICD-9/Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) Codes** – When billing ICD-9 diagnosis codes, crosswalk code services to the highest level of specificity (that is, five-digit level). DSM-IV codes are required for behavioral health conditions.





- **Injectables** – For injectables administered in the office, bill the appropriate HCPCS code for the injectable being administered. When billing for a drug for which there is no defined allowable in the Medicare “J” Code Pricing File, provide the appropriate HCPCS code and the applicable National Drug Code printed on the manufacturer’s drug packaging label in Column 24D of the CMS-1500 claim form. Ensure that the appropriate units are indicated in Column 24G of the CMS-1500 claim form.
- **Itemization/breakdown of charges** – Be sure to complete Section 24, Columns A–J (for example, place of service, charges in Column F, date of service) of the CMS-1500 claim form to ensure that charges are itemized correctly.
- **Laser surgery** – Submit claims for laser surgery with a laser-specific CPT code for appropriate reimbursement. Without the laser surgery code, the claim will be reimbursed as a conventional surgical procedure.
- **Maternity antepartum care** – Submit claims with the appropriate level of service codes. Refer to the current edition of the CPT publication.
- **Modifiers and condition codes** – Industry standard modifiers and condition codes may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply when billing.
- **National Provider Identifier** – Include all applicable National Provider Identifiers (NPIs). TRICARE providers should already have NPIs. If you do not have an NPI, complete the online [National Plan & Provider Enumeration System application](#) or download a paper application of the [National Provider Identifier \(NPI\) Application/Update form](#).
- **Other health insurance (OHI)** – Always ask the patient if he or she has OHI. It is your responsibility to submit OHI benefit information in Boxes 4, 9, 11 and 29 on the CMS-1500 claim form or FL 34, 50, 54 and 58 of the UB-04 claim form, or submit an explanation of benefits (EOB) statement from the OHI carrier along with the TRICARE claim if submitting a paper claim. For EDI billing instructions, visit [PGBA's](#) website.
Note: You may not bill the beneficiary for cost-shares or copayments when the OHI has paid more than the contractual TRICARE allowable charge.
- **Out-of-region claims** – Submit claims to the TRICARE region where the beneficiary resides and/or is enrolled. Refer to Processing Claims for Out-of-Region Care later in this section.
- **Outpatient hospital clinic billing** – When billing for provider outpatient services in a hospital setting, the following guidelines must be followed. This allows the claim to process in a timely manner and keeps the TRICARE beneficiary from being charged a double copayment.
 - **Hospital:** Bill revenue code 510 on a UB-04 institutional claim form.
 - **Provider:** Bill Place of Service (POS) 22 on a CMS-1500 claim form. **Do not use** POS 11 or the beneficiary will receive a separate copayment from the hospital.
- **Physician assistants/nurse practitioners** – When billing for a physician assistant or any other rendering provider (other than the individual provider shown in Box 33 of the claim form), you must include the provider’s NPI in Column 24 of the CMS-1500 claim form.
- **Place of service codes** – Use the correct place of service codes (see Box 24B of the CMS-1500 claim form).
- **Prior authorization** – Certain services require a prior authorization from Health Net.
Note: Per [TRICARE Reimbursement Manual, Ch. 1, Sec. 28](#) network and non-network provider claims submitted for services rendered without a required prior authorization are subject to a 10 percent penalty of the negotiated rate. For a network provider, the penalty may be greater than 10 percent depending on whether his or her network contract includes a higher penalty. These payment reduction penalties cannot be passed onto the beneficiary for payment. It is the provider’s responsibility to obtain prior authorization when required.
- **Provider signature** – Always include the provider’s signature or use a signature stamp in Box 31 of the CMS-1500 claim form. The signature stamp must be on file with Health Net/PGBA. “Signature on File” is an acceptable signature on electronic claims only. Because the provider’s signature block FL was eliminated from the UB-04 institutional claim, the National Uniform Billing Committee has designated FL 80 (Remarks) as the location for the provider



signature if signature-on-file requirements do not apply to the claim.

Note: All non-network claims must have a provider's signature or an acceptable facsimile, in accordance with the [TRICARE Operations Manual, Ch. 8, Sec. 4](#). If a non-network claim does not contain an acceptable signature, the claim will be returned.

- **Services provided on behalf of another provider**
– Always clearly indicate “On Call” in a prominent place on the CMS-1500 claim form for services performed on behalf of another provider. If submitting paper claims, do not use red ink stamps.
- **Services that require specific units of service**
– When billing for these services, such as allergy testing and treatment, be sure to code units of service based on the description in the most current edition of the [CPT publication](#).
- **Tax Identification Number and address** – All claims must include the provider's federal Tax Identification Number (TIN) in Box 25 of the CMS-1500 claim form, the provider's physical address (including ZIP code) in Box 32 and the provider's pay-to address and ZIP code in Box 33. On the UB-04 institutional claim form, enter the physical address of the facility where the care was provided in the Form Locator (FL) 1 field and enter the pay-to address in the FL 2 field. The facility's federal TIN is entered in the FL 5 field.
- **Third party liability (TPL)** – If billing for care that may involve TPL (ICD-9 codes 800–999), instruct the beneficiary to promptly respond to any request for TPL information. Once the beneficiary returns the signed TPL form (DD Form 2527 [Statement of Personal Injury—Possible Third Party Liability](#)) to Health Net, the claim will be processed.
- **TRICARE summary payment voucher/remittance** – You will receive a copy of the TRICARE Summary of Payment Voucher/Remittance with your payment from Health Net. The TRICARE Summary of Payment Voucher/Remittance will reflect the services provided that pertain to the payment. You can also view online remittances through the [Health Net](#) and [PGBA](#) websites.

- **Unlisted or unspecified CPT codes** – When submitting a paper claim and billing with an unlisted or unspecified CPT procedure code, you must include supporting documentation describing the services rendered or the claim will be returned for this information. For electronic claims, include the codes; PGBA will request additional information from you when applicable.
- **XPressClaim®** – [XPressClaim](#) is a fast, easy and free real-time, online claims processing system available through the [Health Net](#) and [PGBA](#) websites. See "Electronic Claims Submission" later in this section for more information.

Behavioral Health Care Claim Tips

The following are behavioral health care claims tips:

- Behavioral health care includes the ICD-9/*Diagnostic and Statistical Manual of Mental Disorders* (DSM)-IV diagnosis range 290.0–314.9. Only physicians and other licensed or certified behavioral health care providers may bill for psychiatric CPT codes or ICD-9/DSM-IV diagnoses.
- File hospital and other institutional care claims on UB-04 forms.
- File professional services claims on Centers for Medicare & Medicaid Services (CMS)-1500 forms.
- Professional providers should use CPT procedure codes and DSM-IV diagnosis codes to bill for services.
- Facilities should use revenue and HCPCS codes (if required) to bill for services.
- Properly inform beneficiaries in advance if services are not covered. You are financially responsible for any non-covered services you provide to a TRICARE beneficiary who was not properly informed in advance of non-coverage and/or who did not agree in advance and in writing to pay for the non-covered services. See [Informing Beneficiaries about Non-Covered Services and TRICARE's Hold Harmless Policy](#) in the *Important Provider Information* section of this handbook for more information.



- Check claims status at www.hnfs.com or call **1-877-TRICARE (1-877-874-2273)**. Claim check services are available 24 hours a day, seven days a week.
- If Health Net denies a claim because you did not obtain required authorization, follow instructions on the remittance statement or call Health Net at **1-877-TRICARE (1-877-874-2273)** for assistance.

For more information about Partial Hospitalization Programs (PHPs), refer to the *TRICARE Reimbursement Manual (TRM), Ch. 7, Sec. 2.* To learn more about outpatient prospective payment system (OPPS), refer to the *TRICARE Reimbursement Methodologies* section of this handbook or *TRICARE Reimbursement Manual, Ch. 13, Sec. 2.*

Health Insurance Portability and Accountability Act Transaction Standards and Code Sets for Behavioral Health Claims

All health care providers, plans and clearinghouses are required to comply and must use the following standard formats for TRICARE behavioral health care claims:

- ASC X12N 837 – Health Care Claim: Professional, Version 5010 and Addenda
- ASC X12N 837 – Health Care Claim: Institutional, Version 5010 and Addenda

TRICARE contractors (Health Net and PGBA) and other health care payers are prohibited from accepting or issuing transactions that do not meet these standards. For more information on Health Insurance Portability and Accountability Act transaction standards and code sets, see the *Important Provider Information* section of this handbook.

Proper Billing for Multiple Procedures

Do not use the same CPT code billed on multiple lines for the same date of service instead of one line with multiple units. If there are multiple dates of service, each line should be billed separately.

The following are examples for billing a pathology exam on three breast biopsy specimens on the same date of service:

- Correct way: One line with the CPT code and 3 units
- Wrong way: Three lines with the CPT code with 1 unit each

If the claim includes three lines with one unit for each line on the same date of service, the additional lines appear as duplicates causing the additional lines to deny.

Medically Unlikely Edit (MUE)

TRICARE has adopted the Centers for Medicare and Medicaid Services (CMS) maximum number of services limitations. CMS defines a Medically Unlikely Edit (MUE) as "... the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service." TRICARE's maximum number of services per day which may be billed for specific CPT codes can be found at the *TRICARE Management Activity* (TMA) website. If the number of procedures performed in a day exceeds the MUE, medical documentation will be required to prove the procedures were medically necessary.

Avoid Duplicate Claims

Duplicate claims occur when providers resubmit claims that have already been processed through to completion. In many instances, duplicate claims have been previously processed for payment. In other situations, claims have been processed for partial payment or possibly denied.

To avoid submitting duplicate claims, providers should reconcile their financial records as soon as possible to avoid the impression of an unpaid balance.

Duplicate claims add unnecessary processing costs that must be paid by the government, not to mention the additional administrative costs to your practice. Keeping unnecessary health care costs low is a responsibility of all members of the health care community.

Through *PGBA's* website you can:

- Check TRICARE claims status online to verify completed, in process/pending, returned or transferred claims.



- Reconcile your accounts receivables by viewing TRICARE remits online.
- Sign up for EFT to receive TRICARE payments faster.
- Ensure provider demographic information on file is up-to-date and accurate.

Note: Wait at least 30 days before claims resubmission or telephone inquiry. Check the status of a claim at the **PGBA** website or by using the IVR system at **1-877-TRICARE (1-877-874-2273)**.

If, after reconciling your accounts, you determine payment has not been received or you disagree with the payment amount, do not resubmit the same claim. Instead, explain your circumstance or disagreement by requesting a **claim review** and faxing written correspondence to **1-888-432-7077**.

Electronic Claims Submission

Electronic claims submission allows you to submit claims directly to Health Net/PGBA, ensuring faster processing and reduced paperwork. Network providers are required to submit all claims electronically. Non-network providers are strongly encouraged to submit claims electronically.

The following are options for electronic claims submission:

- XPressClaim – A secure, full service online electronic claims system recommended for providers with Internet access who submit fewer than 150 TRICARE claims per month. This service is free, requires no additional hardware or software, accepts CMS-1500 and UB-04 claims, will adjudicate most TRICARE claims upon submission and provides a clear explanation of what TRICARE allows and what the patient owes. See "XPressClaim Online Claim Processing System" later in this section for more details.
- Claims clearinghouses – You can establish clearinghouse services to transmit TRICARE claims electronically to Health Net/PGBA for processing. This option allows you to submit claims to other health care payers as well.

For assistance, visit **PGBA's** website or call **1-877-EDI-CLAIM (1-877-334-2524)**.

XPressClaim Online Claims Processing System

XPressClaim offers a secure Internet-based, real-time, online claim-processing system to transmit TRICARE claims 24 hours a day, seven days a week. XPressClaim uses a sophisticated encryption technology to transmit claims securely. The system fully protects the confidentiality of patient records and complies with HIPAA rules and regulations.

Registered members of myTRICARE Secure for providers can sign up for XPressClaim by accessing the registration portal and creating a unique username and password. You and other office staff can register instantly for both myTRICARE Secure for Providers and XPressClaim on **PGBA's** website.

After registration, XPressClaim will preload patient information for your TRICARE patients from claims that have been processed within the past 12 months. To enter a new patient's information, you need the sponsor's SSN and the patient's date of birth. You can use XPressClaim to reconcile claim payments and check a TRICARE patient's claim status, eligibility and OHI information.

XPressClaim can also handle claims submission for groups with multiple locations and multiple providers. To file claims, you will need the following:

- dates of service
- standard ICD-9 diagnosis and CPT-4 procedure codes
- basic data related to the diagnosis





Note: You can submit up to 49 lines of information on one XPressClaim submission.

Immediately after claim submission, you will receive an online message showing the claim has been accepted for processing. The system also shows the TRICARE allowable charge and the patient's payment responsibility (if any). You can generally expect PGBA to mail payment within three to five days. If a claim is more complicated and needs to be resolved by PGBA, dedicated associates will process the claim as a priority. In most cases, these claims will be complete within 10 days or fewer

Electronic Funds Transfer

You can sign up for EFT on [PGBA's](#) website. You must have signature authority, which means you are authorized to disburse funds; sign checks; and add, modify or remove bank account information.

Claims Submission Addresses

Figure 7.1 provides a listing of addresses related to paper claim submission for individual, institutional, ancillary, and behavioral health care providers.

North Region Submission Addresses *Figure 7.1*

Claims Submission	Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740
Claims Correspondence	Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870141 Surfside Beach, SC 29587-9741
Non-Network and Network Provider Reconsideration of Claims Under Administrative Review Process	Health Net Federal Services, LLC Administrative Reviews P.O. Box 105266 Atlanta, GA 30348-5266

Hospital and Facility Billing

- **Emergency room charges** in conjunction with a DRG-reimbursed hospital stay must be billed on a separate outpatient UB-04. Additionally, ambulatory surgery room charges cannot be submitted on an inpatient claim and should be billed as a separate outpatient service on the UB-04.
- **Interim claims for DRG-based facilities** (regardless of the type of contract with Health Net) are accepted when the patient has been in the hospital at least 60 days. If you submit multiple claims on one patient's behalf, you must submit them in chronological order. Fixed-dollar parameters do not apply.
- **Hospital-based outpatient surgical procedures** are reimbursed under the TRICARE Outpatient Prospective Payment System (OPPS). Some hospitals are exempt from OPPS. This is mandatory for both network and non-network providers. TRICARE's OPPS closely mirrors Medicare's OPPS method; however, the TRICARE program determines benefits and coverage for the entire military population, regardless of age. For a list of exempt facilities, procedure code change for TMA's No Government Pay List (NGPL) and more information regarding TRICARE OPPS implementation, refer to the [TRICARE Reimbursement Manual, Ch. 13](#). TRICARE-OPPS exempt facilities reimburse rates established by TMA for outpatient surgical procedures. To ensure proper payment for procedures listed on the [TMA Ambulatory Surgery Center \(ASC\)](#) make sure that ICD-9 surgical procedure codes have a corresponding CPT-4 code and a charge for each CPT-4 code billed.
- **Certain surgical procedures** normally reimbursed at a hospital-based surgery center can also be reimbursed at a freestanding ASC. TRICARE network providers must contact Health Net to obtain prior authorization for appropriate procedures performed at an ASC. Refer to the [TRICARE Policy Manual, Ch. 11](#) for more information.
- **Hospital clinic billing** – When billing for provider outpatient services in a hospital setting, the following guidelines must be followed. This allows the claim to process in a timely manner and keeps the TRICARE beneficiary from being charged a double copay.



- **Hospital:** Bill revenue code 510 on a UB-04 institutional claim form.
- **Provider:** Bill Place of Service (POS) 22 on a CMS-1500 claim form. **Do not use** POS 11 or the beneficiary will receive a separate copay from the hospital.

Proper Treatment and Observation Room Billing

Revenue Code 076X

Determining when to use revenue code 076X (treatment) to indicate use of a treatment room can be complicated and improper coding can lead to inappropriate billing.

Under OPSS, 0760-series revenue codes are reimbursed based on the HCPCS codes submitted on the claim.

You may indicate revenue code 076X for the actual use of a treatment room in **which a specific procedure has been performed or a treatment rendered**. Revenue code 076X may be appropriate for charges for minor procedures and in the following instances:

- outpatient surgery procedure code
- interventional radiology services related to imaging, supervision, interpretation, and the related injection or introduction procedure
- debridement performed in an outpatient hospital department

Revenue Code 0762 (observation room) is the only revenue code that should be used for observation billing. Non-OPSS outpatient observation stays may be reimbursed for a maximum of 48 hours.

Billing with V Codes

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: V-code diagnoses for TRICARE behavioral health care services are not covered. TRICARE policy defines V-code diagnoses as "conditions not attributable to a mental disorder."

How to Bill with V Codes

Be sure to use the correct V-code diagnosis to indicate the reason for the patient's visit. The V code **must match the CPT code to indicate a given procedure's correlation to the V-code diagnosis**. V codes correspond to descriptive, generic, preventive, ancillary or required medical services and should be billed accordingly. This section covers different types of V codes and their uses.

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 is a routine infant or well-child visit, which is designated as V20.2.

Generic V Codes

For lab, radiology, pre-op or similar services, do not use a generic V code 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 mammography; a Pap smear, also referred to as a Pap test; or a fecal occult blood screening.

Figure 7.2 lists preventive services and the corresponding V codes.





Preventive Care Services V Codes

Figure 7.2

Preventive Care Service	Proper V Codes	Care Intervals and Notes
Colonoscopy	V76.51 V16.0 V12.72	Refer to "Preventive Services" in Section 4 of this handbook for more information.
Mammograms	V76.11 V76.12 V10.3	The mammogram and add-on codes must be submitted on the same claim if performed on the same date of service. Refer to "Preventive Services" in Section 4 of this handbook for more information.
Optometry (eye exams)	V72.0	Well-Child Benefit: Use V20.2 The V code can be used for the annual routine vision exam and may be used by optometrists for this purpose. However, if a medical condition is identified, use medical diagnosis CPT codes. V72.0 may not be used if the optometrist or ophthalmologist bills an evaluation and management code. Refer to "Preventive Services" in Section 4 of this handbook for more information.
Pap Test	V72.3 V76.2	Refer to "Preventive Services" in Section 4 of this handbook for more information.
Proctosigmoidoscopy and sigmoidoscopy	V76.41 V76.51 V16.0 V12.72	Refer to "Preventive Services" in Section 4 of this handbook for more information.
Regular Immunizations	V20.2 (includes well-child check)	Refer to "Preventive Services" in Section 4 of this handbook for more information.
School Physical Note: Sports-related physical exams are not a covered benefit.	V70.0 V70.3 V70.5 V70.9	Refer to "Preventive Services" in Section 4 of this handbook for more information.
Well-Child Visits (birth to six years)	V20.2	Refer to "Preventive Services" in Section 4 of this handbook for more information.

Allergy Testing and Treatment Claims

TRICARE does not cover certain types of allergy tests. Prior to performing an allergy test, visit the [Health Net](#) website to verify if the test is an approved benefit.

When submitting claims for allergy testing and treatment, use the appropriate CPT code and indicate on the claim form the type and number of allergy tests performed. When filing claims for the administration of multiple allergy tests, group the total number of tests according to the most current CPT-4 code book definitions of relevant codes. Under Column 24G of the CMS-1500 claim form,

indicate the number of replacement antigen sets (not vials) being billed.

Pending medical review and approval, a limited number of replacement antigen sets are payable. Bill with the appropriate CPT code per replacement antigen set quantity (for example: one vial, two or more vials).

Eye Exam Claims

TRICARE covers routine eye exams every 12 months for TRICARE Prime and TRICARE Prime Remote beneficiaries with diabetes. Routine exams must be billed differently from a diagnostic eye exam to ensure claims are processed accurately.



Routine Exams

A routine eye exam may include, but is not limited to: refractive services, comprehensive screening for determination of vision or visual acuity, ocular alignment and red reflex, dilation and external examination for ocular abnormalities. The covered CPT® codes for routine eye exams are: 92002, 92004, 92012, 92014, 92015, 99172 and 99173. The claim should include a routine vision screening diagnosis as the primary diagnosis and a diabetes diagnosis as secondary. Failure to include the routine diagnosis or using an evaluation and management (E&M) procedure code may cause the claim to process as a diagnostic exam. Any claim for a routine eye exam performed less than 12 months since the previous routine eye exam will require medical necessity documentation.

Diagnostic Exams

TRICARE covers diagnostic exams for the treatment of a confirmed or suspected eye condition. A diagnostic exam may be billed with evaluation and management (E&M) procedure codes like 992x4 along with the appropriate diagnosis code identifying the patient's eye condition. A diabetes diagnosis could be the primary diagnosis or a secondary diagnosis. Diagnostic exams can be billed with eye exam CPT codes 92002, 92004, 92012, 92014, 92015, 99172, 99173, or the E&M codes.

For **eye exam benefit** details, refer to the *Medical Coverage* section.

Global Maternity Claims

Global maternity involves the billing process for maternity-related beneficiary claims. After confirming that a patient is pregnant, all charges related to the pregnancy are grouped under one global maternity diagnosis code as the primary diagnosis. Figure 7.3 lists examples of these codes.

Global Maternity Diagnosis Code Examples

Figure 7.3

Code	Description
V22	Normal pregnancy
V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V22.2	Pregnant state, incidental

When TRICARE Prime and TPR beneficiaries are referred for specialty obstetric care, the primary care manager (PCM) submits a service request notification to Health Net.

Professional and technical components of medically necessary fetal ultrasounds are covered outside of the maternity global fee. The medically necessary indications include, but are not limited to, clinical circumstances that require obstetric ultrasounds to estimate gestational age, evaluate fetal growth, conduct a biophysical evaluation for fetal well-being, evaluate a suspected ectopic pregnancy, define the cause of vaginal bleeding, diagnose or evaluate multiple gestations, confirm cardiac activity, evaluate maternal pelvic masses or uterine abnormalities, evaluate suspected hydatidiform mole and evaluate fetus condition in late registrants for prenatal care.

Maternal Serum Alpha Fetoprotein and Multiple Marker Screen Test are cost-shared separately (outside of the global fee) as part of the maternity care benefit to predict fetal developmental abnormalities or genetic defects. A second phenylketonuria test for infants is allowed if administered one to two weeks after discharge from the hospital as recommended by the American Academy of Pediatrics.

Claims for Mutually Exclusive Procedures

Mutually exclusive procedures are two or more procedures that are usually not performed during the same patient encounter on the same date of service. Generally, there is significant overlapping of services and duplication of effort with mutually exclusive procedures. Mutual exclusivity rules may also include different procedure code descriptions for the same type of procedure although only one procedure code applies. For example, vaginal hysterectomy and abdominal hysterectomy are considered mutually exclusive.



Physician-Administered Drug and Vaccine Claim Filing

The National Drug Code (NDC) number, drug quantity and package unit indicators are necessary on drug and vaccine claim filings when no nationally established TRICARE allowable charge pricing has been set. Visit the [TRICARE Management Activity \(TMA\)](#) website to determine if a TRICARE allowable charge exists for specific drugs or vaccines.

Electronic Data Interchange claims provide the fields for keying the NDC, drug quantity and the package or unit indicator. This is in addition to the HCPCS/CPT drug code and quantity, which can be different from the NDC drug quantity. Where necessary, provide supporting documentation, such as the certificate of medical necessity (CMN), medical records or NDC information. For assistance with EDI claims call the EDI Help Desk (electronic claims) at **1-877-334-2524**.

CMS-1500 hard-copy claims must use the shaded space above each line in the “Lines” field. These shaded areas are for additional information. The 11-digit NDC number (with no spaces or dashes), the drug quantity based on the NDC, and the “P” or “U” indicator should go in the shaded area. The actual line below the shaded area should include the appropriate HCPCS/CPT drug code, and the quantity based on the code must also be included in the “Lines” field. Again, if supporting documentation (such as CMN, medical records, or NDC information) is needed, please include it with the submission of the paper claim.

Processing Claims for Out-of-Region Care

If you provide health care services to a TRICARE beneficiary who resides in or is enrolled in a different region, the beneficiary will pay the applicable cost-share, and you will submit reports and claims information to the region based on the TRICARE beneficiary’s enrollment address, not the region in which he or she received care. If you have a claim issue or question regarding a TRICARE patient who normally receives care in another TRICARE region, call the appropriate region-specific number for assistance.

South Region: 1-800-403-3950

The South Region includes Alabama, Arkansas, Florida, Georgia, Kentucky (Ft. Campbell area), Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and Texas (excluding the El Paso area).

West Region: 1-877-988-WEST (1-877-988-9378)

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.

Claims for Beneficiaries Assigned to US Family Health Plan Designated Providers

Designated providers are facilities specifically contracted with the Department of Defense to provide care to beneficiaries enrolled in the US Family Health Plan (USFHP). The USFHP is offered in six geographic regions in the United States. Although it provides a TRICARE Prime-like benefit, USFHP is a separately funded program that is distinct from the TRICARE program administered by Health Net. The designated provider is responsible for all medical care for a USFHP beneficiary, including pharmacy services, primary care and specialty care.

If you provide care to a USFHP beneficiary outside of the network or in an emergency situation, you must file claims with the appropriate designated provider at one of the addresses listed in Figure 7.4. Do not file USFHP claims with Health Net or PGBA. For more information visit the [USFHP](#) website.



USFHP Designated Providers

Figure 7.4

Martin's Point Health Care P.O. Box 11410 Portland, ME 04104-5040
Brighton Marine Health Center P.O. Box 9195 Watertown, MA 02471-9195
US Family Health Plan at SVCMC P.O. Box 830745 Birmingham, AL 35283-0745
Johns Hopkins Medical Services Corporation 6704 Curtis Court Glen Burnie, MD 21060
CHRISTUS Health US Family Health Plan ATTN: Claims P.O. Box 924708 Houston, TX 77292-4708
Pacific Medical Clinics 1200 12th Avenue South, Quarters 8/9 Seattle, WA 98144-2790

TRICARE Overseas/Foreign Claims

Wisconsin Physicians Service (WPS) is the claims processor for the TRICARE Overseas Program (TOP), TOP-Prime and TOP-Prime Remote all overseas claims. If filing a claim for an ADSM who is enrolled in a TOP option (TOP Prime, TOP Prime Remote or TOP Standard), submit it to the address listed in Figure 7.5. If filing a claim for a non-ADSM who is enrolled in a TOP option, refer to the addresses listed in Figure 7.6.

Overseas claims for National Guard and Reserve members on orders of 30 days or less should be sent to WPS. To expedite claims, the provider should submit a copy of the member's orders with the claim. The orders verify the member's eligibility for TRICARE benefits.

TRICARE Overseas Claims Contact Information—Active Duty Service Members

Figure 7.5

All Overseas areas	TRICARE Overseas ADSM Overseas ADSM P.O. Box 7968 Madison, WI 53707-7968 Hotline: 1-877-451-8659 Fax: 1-215-773-2701 www.tricare-overseas.com
---------------------------	--

TRICARE Overseas Claims Contact Information—Non-Active Duty Service Members

Figure 7.6

TRICARE Eurasia-Africa (Africa, Europe, and the Middle East)	TRICARE Overseas Region 13 P.O. Box 8976 Madison, WI 53707-8976
TRICARE Latin America and Canada (Canada, the Caribbean basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands)	TRICARE Overseas Region 15 P.O. Box 7985 Madison, WI 53707-7985
TRICARE Pacific (Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries)	TRICARE Overseas P.O. Box 7985 Madison, WI 53707-7985

Claims for Beneficiaries Using Medicare and TRICARE For Life

Wisconsin Physicians Service (WPS) is the claims processor for all TRICARE For Life (TFL) claims. If you currently submit claims to Medicare on your patient's behalf, you will not need to submit a claim to WPS. Wisconsin Physicians Service has signed agreements with each Medicare carrier allowing direct, electronic transfer of TRICARE beneficiary claims to WPS. Claims processed by Medicare are submitted electronically to WPS. Beneficiaries and providers will receive an EOB from WPS after processing.



Note: Participating providers accept Medicare’s payment amount. Nonparticipating providers do not accept Medicare’s payment amount and are permitted to charge up to 115 percent of the Medicare-approved amount. Both participating and nonparticipating providers may bill Medicare.

When TRICARE is the primary payer, all TRICARE requirements apply. Refer to the **TRICARE Reimbursement Manual, Ch. 4** for details.

Figure 7.7 contains important contact information for you and your patients regarding Medicare and TRICARE claims.

Medicare and TRICARE Claims Contact Information **Figure 7.7**

Appeals	WPS/TRICARE For Life ATTN: Appeals P.O. Box 7490 Madison, WI 53707-7490
Claims submission Note: Submit claims to Medicare first.	WPS/TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890
Customer service	WPS/TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889
Online	www.TRICARE4u.com
Program Integrity	WPS/TRICARE For Life ATTN: Program Integrity P.O. Box 7516 Madison, WI 53707-7516
Refunds	WPS/TRICARE For Life ATTN: Refunds P.O. Box 7928 Madison, WI 53707-7928
Third-party liability	WPS/TRICARE For Life ATTN: TPL P.O. Box 7897 Madison, WI 53707-7897
Toll-free telephone	1-866-773-0404
Toll-free TDD	1-866-773-0405

Claims for Foreign Military Beneficiaries

Foreign military members and their family members in the United States may be eligible for TRICARE under an approved agreement (for example, reciprocal health care agreement, North Atlantic Treaty Organization [NATO] Status of Forces Agreement [SOFA], Partnership for Peace [PFP] SOFA). Foreign nations’ armed forces members who are stationed in the United States or are guests of the U.S. Government may receive the same benefits as American ADSMs, including no out-of-pocket expenses for care directed by the MTF. Eligible accompanying family members can receive outpatient services under TRICARE Standard. A copy of the family member’s identification card will have a foreign identification number or an actual SSN and indicate on the reverse “Outpatient Services Only.”

Foreign family members do not need MTF referrals prior to receiving outpatient services from network providers. Foreign family members follow the same prior authorization requirements as TRICARE Standard beneficiaries and are responsible for TRICARE Standard deductibles and cost-shares. To collect charges for services not covered by TRICARE, you must have the foreign military family member agree, in advance and in writing, to accept financial responsibility for any non-covered service. Download a copy of the **Request for Non-Covered Services** form at the Health Net website.

Claims for foreign military members and their family members should be filed electronically the same way other TRICARE claims are submitted. If claims are submitted by mail, submit to:

Health Net Federal Services, LLC
c/o PGBA, LLC/TRICARE
PO Box 870140
Surfside Beach, SC 29587-9740

TRICARE will not cover inpatient services for foreign military members. To be reimbursed for inpatient services, have the member make the appropriate arrangements with their national embassy or consulate in advance. Foreign military member eligibility is maintained in the Defense Enrollment Eligibility Reporting System (DEERS). Claims submission procedures are the same as for U.S. ADFMs in the United States.



Claims for Civilian Health and Medical Program of the Department of Veterans Affairs

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is not a TRICARE program. For questions or general correspondence, you may contact CHAMPVA by any of the following means:

Phone	1-800-733-8387
Mail	VA Health Administration Center CHAMPVA P.O. Box 469063 Denver, CO 80246-9063
Website	www.va.gov/hac/forproviders

Claims for current treatment must be filed within 365 days of the date of service. Providers may file health care claims electronically on behalf of their patients. If you wish to file a paper health care claim, download CHAMPVA claim forms from the CHAMPVA website, and file them within the one-year claim-filing deadline. Send the claim to:

VA Health Administration Center CHAMPVA
P.O. Box 469064
Denver, CO 80246-9064

You may submit a written appeal if exceptional circumstances prevent you from filing a claim in a timely fashion. Send written appeals to:

VA Health Administration Center CHAMPVA
ATTN: Appeals
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 in Denver, Colorado, within 72 hours of identifying the CHAMPVA claim. A letter will be sent to the claimant informing him or her of the transfer. The letter includes instructions on how to submit future CHAMPVA claims and to direct any correspondence for CHAMPVA beneficiaries to the CHAMPVA VA Health Administration Center.

Claims for the Continued Health Care Benefit Program

Humana Military is the contractor for the **Continued Health Care Benefit Program** (CHCBP) and has partnered with PGBA for processing non-overseas CHCBP claims. Health Net does not administer this program. Continued Health Care Benefit Program beneficiaries may request providers file medical claims on their behalf. For questions and assistance regarding CHCBP claims, call PGBA at **1-800-403-3950**. You may file CHCBP claims electronically through www.mytricare.com. File all paper claims at one of the addresses listed in Figure 7.8.

CHCBP Claims

Addresses

Figure 7.8

CHCBP adjunctive dental claims

P.O. Box 7037
Camden, SC 29020-7037

CHCBP behavioral health claims

P.O. Box 7034
Camden, SC 29020-7034

All Other CHCBP Claims

P.O. Box 7031
Camden, SC 29020-7031

Claims for the Extended Care Health Option

All claims for the Extended Care Health Option (ECHO) and the Enhanced Access to Autism Services Demonstration (Autism Demonstration) must have a valid written authorization.

All claims for ECHO-authorized care (including ECHO Home Health Care and the Autism Demonstration) should be billed on individual line items. Unauthorized ECHO care claims will be denied.

Extended Care Health Option claims will be reimbursed for the amount authorized (indicated on the written authorization provided by Health Net) or the monthly or fiscal year benefit limit, whichever is lower. Each line item on an ECHO claim needs to correspond to a line item on the service authorization, or the claim may be denied or delayed due to research and reconciliation.



The billed amount for procedures should reflect the service, not the applicable ECHO benefit limits. Pricing of ECHO services and items is determined in accordance with the [TRICARE Reimbursement Manual](#). Refer to the [TRICARE Policy Manual, Ch. 9](#) and the [TRICARE Operations Manual, Ch. 18](#) for additional claims information.

Claims for TRICARE Reserve Select, TRICARE Retired Reserve and TRICARE Young Adult

All beneficiaries covered under [TRICARE Reserve Select](#) (TRS) and [TRICARE Retired Reserve](#) (TRR) follow the applicable cost-shares, deductibles and catastrophic caps for TRICARE Standard. TRICARE Reserve Select cost-shares follow the applicable cost-shares, deductibles and catastrophic caps for ADFMs. TRICARE Retired Reserve cost-shares, deductibles and catastrophic caps match retiree cost-shares.

All beneficiaries covered under [TRICARE Young Adult](#) (TYA) Standard or Prime should follow the applicable cost-shares, deductibles and catastrophic caps based upon sponsor status and TYA plan option.

Note: Eligible young adults whose sponsors have either TRS or TRR are only eligible for TYA Standard and not TYA Prime.

TRICARE Network Providers

- File claims with PGBA electronically for TRS, TRR and TYA members just as you would file other TRICARE claims.
- Submit claims through [PGBA's](#) website.
- The cost-share for all TRS members, including National Guard and Reserve members, is 15 percent of the negotiated fee for covered services from TRICARE network providers. TRICARE will reimburse the remaining amount of the negotiated fee.
- The cost-share for all TRR-covered members is 20 percent of the negotiated fee for covered services from TRICARE network providers. TRICARE will reimburse the remaining amount of the negotiated fee.

TRICARE-Authorized Non-Network Providers

- Participation with TRICARE (for example, accepting assignment, filing claims and accepting the TRICARE allowable charge as payment in full) is encouraged, but not required, on TRS, TRR and TYA claims.
- Non-network providers are encouraged to submit their TRICARE claims electronically.
- The cost-share for all TRS-covered members is 20 percent of the TRICARE allowable charge for covered services from non-network TRICARE-authorized providers. TRICARE will reimburse the remainder of the TRICARE allowable charge.
- The cost-share for all TRR-covered members is 25 percent of the TRICARE allowable charge for covered services from network TRICARE-authorized providers. TRICARE will reimburse the remainder of the TRICARE allowable charge.
- Beneficiaries will file their own reimbursement claims with TRICARE and then pay the non-network provider, if a non-network provider does not participate on a particular claim.

Note (for non-network providers): By federal law, if a non-network provider does not participate on a particular claim, the provider may not charge more than 15 percent above the TRICARE allowable charge. The TRICARE allowable charge schedules can be found on [TRICARE Management Activity's](#) (TMA) website.

Supplemental Health Care Program Claims

The Supplemental Health Care Program (SHCP) covers any civilian health care service as long as either the MTF refers the patient or the Military Medical Support Office (MMSO)/service point of contact (SPOC) authorizes the care. Claims for SHCP are processed and paid through Health Net/PGBA. Supplemental Health Care Program claims must be submitted electronically or mailed to the address below:

Health Net Federal Services, LLC
c/o PGBA, LLC/TRICARE
PO Box 870140
Surfside Beach, SC 29587-9740



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.

TRICARE and Other Health Insurance

Other health insurance (OHI) must be used before TRICARE. Health coverage through an employer, an association, a private insurer, school health care coverage for students and Medicare are always primary to TRICARE. Even health care through an auto insurance plan is considered OHI when services are related to an auto accident.

Exceptions are: Medicaid, State Victims of Crime Compensation Programs, the Indian Health Service or other programs or plans as identified by TRICARE Management Activity (TMA).

Services must be provided by a TRICARE-authorized provider and all requirements of the OHI plan must be followed. If the OHI denies a claim because OHI authorization requirements were not followed or because a network provider was not used, TRICARE will deny the claim and the patient will be responsible for the denied charges.

The OHI must process the claim before TRICARE can consider the charges.

If the OHI denies the claim as not medically necessary, all appeal rights with the OHI must be used before TRICARE can process the claim. TRICARE benefits can only be considered after all avenues of appeal available with the OHI have been pursued.

TRICARE may become the primary payer if OHI benefits are exhausted or if the primary OHI does not cover a service or supply. If TRICARE becomes the primary payer, additional prior authorization requirements may apply.

Health Net must have current OHI information to process claims appropriately. It is the beneficiary's responsibility to notify Health Net of any changes. Beneficiaries may print, complete and mail the TRICARE Other Health Insurance Questionnaire form if there are any changes to OHI coverage. Fax the completed form(s) to **1-888-237-6262**.

It is very important to ensure providers have accurate information regarding OHI and TRICARE coverage. Incorrect information submitted by a provider could cause unnecessary delays or denials.

When a TRICARE-eligible beneficiary has OHI, submit a claim using the guidelines in Figure 7.9.

Other Health Insurance Claims

Figure 7.9

<p>Identify OHI in the claim form</p>	<p>To identify OHI in the claim form:</p> <ul style="list-style-type: none"> • Mark "Yes" in Box 11 (CMS-1500) or FL (UB-04) • Indicate the primary payer in Box 9 (CMS-1500) or FL 50 (UB-04). • Indicate the amount paid by the OHI in Box 29 (CMS-1500) or FL 54 (UB-04). • Indicate insured's name in Box 4 (CMS-1500) or FL 58 (UB-04). • Indicate the allowed amount of the OHI in FL 39 (UB04) using value code 44 and entering the dollar amount.
<p>Payment guidelines</p>	<ul style="list-style-type: none"> • If TRICARE is the secondary payer, submit the claim to the primary payer first. If the claim processor's records indicate that the beneficiary has one or more primary insurance policies, submit explanation of benefit (EOB) information from other insurers along with the TRICARE claim. • Health Net/PGBA will coordinate benefits when a claim has all of the necessary information (for example, billed charges, beneficiary's copayment and OHI payment). In order for Health Net/ PGBA to coordinate benefits, the EOB must reflect the patient's liability (copayment and/or cost-share), the original billed amount, the allowed amount, and/or any discounts. If the EOB indicates that a primary carrier has denied a claim due to failure to follow plan guidelines or utilize network providers, TRICARE will also deny the claim.



<p>Payment Guidelines</p>	<p>TRICARE does not always pay the beneficiary’s copayment or the balance remaining after the OHI payment. However, the beneficiary liability is usually eliminated. The beneficiary should not be charged the cost-share when the TRICARE EOB shows no patient responsibility. Payment calculations differ by provider status as detailed below. With TRICARE network providers and non-network providers that accept TRICARE assignment, TRICARE pays the lesser of:</p> <ul style="list-style-type: none"> • the billed amount minus the OHI payment • the amount TRICARE would have paid without OHI • the beneficiary’s liability (OHI copayment, cost-share, deductible, etc.) <p>Non-network providers who do not accept TRICARE assignment may only bill the beneficiary up to 115 percent of the TRICARE allowable charge. If the OHI paid more than 115 percent of the allowed amount, no TRICARE payment is authorized, the charge is considered paid in full, and the provider may not bill the beneficiary. If the service is not covered by TRICARE, the beneficiary may be liable for these charges.</p> <ul style="list-style-type: none"> • TRICARE pays the lesser of 115 percent of the allowed amount minus the OHI payment • the amount TRICARE would have paid without OHI • the beneficiary’s liability (OHI copayment, cost-share, deductible, etc.) <p>When working with OHI, all TRICARE providers should keep in mind TRICARE will not pay more as a secondary payer than it would have as a primary payer. point of service (POS) option cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. However, the beneficiary must have prior authorization for inpatient behavioral health services, regardless of whether or not he or she has OHI.</p>
----------------------------------	---

In some cases, the TRICARE Summary Payment Voucher/Remit will state, “Payment reduced due to OHI payment,” and there may be no payment and no beneficiary liability. The TRICARE cost-share (the amount of cost-share that would have been taken in the absence of primary insurance) is indicated on the TRICARE Summary Payment Voucher/Remit only to document the amount credited to the beneficiary’s catastrophic cap.

Note: For EDI claims, visit [PGBA’s](#) website.

TRICARE and Third-Party Liability Insurance

The Federal Medical Care Recovery Act allows the government to be reimbursed for costs associated with treating a TRICARE beneficiary who has been injured in an accident caused by someone else.

When a claim appears to have possible third-party involvement, certain necessary actions can affect total processing time. Health Net is responsible for identifying and investigating all potential third-party recovery claims.

Inpatient claims submitted with diagnosis codes between 800 and 999 (with some exclusions, as listed in Figure 7.10), regardless of the billed amount, and claims for professional services that exceed a TRICARE liability of \$500, which indicate an accidental injury or illness, will be flagged for research. Claims will not be processed further until the beneficiary completes and submits a **Statement of Personal Injury—Possible Third Party Liability** (DD Form 2527).

There are certain diagnosis codes that are exceptions. A DD Form 2527 is not required for certain diagnosis codes, specifically those listed in Figure 7.10.



Diagnosis Codes Exceptions/Exclusions *Figure 7.10*

- 910.2–910.7
- 911.2–911.7
- 912.2–912.7
- 913.2–913.7
- 914.2–914.7
- 915.2–915.7
- 916.2–916.7
- 917.2–917.7
- 918.0
- 918.2
- 919.2–919.7

When a claim is received which appears to have possible third-party involvement, the following process will occur:

- The DD Form 2527 will be mailed to the beneficiary.
- The claim is suspended for up to 35 calendar days, during which time the beneficiary is expected to complete and return the form.
- If the DD Form 2527 is not received within 35 calendar days, the claim will be denied and “Requested third party liability information not received” will appear on the EOB.
- The claim will be reprocessed when the DD Form 2527 is completed and returned by the beneficiary. Encourage the beneficiary to fill out, sign and return 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) falls between 800 and 999, the beneficiary is still responsible for filling out, signing and returning DD Form 2527. If the form is not returned the claim will be denied, and you may bill the beneficiary.

If you believe a patient needs to complete the DD Form 2527 based on the information above, it is appropriate to have copies of the form on hand for the patient to complete. Taking this precautionary step can help expedite the claim-submission process and ensure timely reimbursement. The **Statement of Personal Injury—Possible Third Party Liability** (DD Form 2527) is available on Health Net’s website. Fax completed forms to **1-888-228-2717**.

TRICARE and Workers’ Compensation

TRICARE will not share costs for services for work-related illnesses or injuries covered under workers’ compensation programs.

Avoiding Collection Activities

Both network and non-network providers are encouraged to explore every possible means to resolve claims issues without involving debt collection agencies. In cases where the claim has been denied, payment has been reduced or is pending, visit **PGBA’s** website to check the status of the claim. Also, you may request a review in writing.

Network providers are to accept the TRICARE allowable charge as payment in full for covered services. Refer to the *Important Provider Information* section of this handbook for additional information about provider and beneficiary payment responsibilities.

Beneficiaries are responsible for their out-of-pocket expenses reflected on the TRICARE Summary Payment Voucher/Remit, including deductible, cost-share and/or copayment amounts.

TRICARE’s Debt Collection Assistance Officer Program

Debt Collection Assistance Officers (DCAOs) are located at each TRICARE Regional Office and MTF to assist TRICARE beneficiaries with collection-related issues. The DCAO cannot provide beneficiaries with legal advice or fix their credit ratings, but DCAOs can help beneficiaries through the debt collection process by providing documentation for the collection or credit reporting agency in explaining the circumstances relating to the debt. Beneficiaries can access the DCAO directory via the TMA website.

When meeting with a DCAO, beneficiaries must take or submit documentation (for example, debt collection letters, EOBs and medical/dental bills from providers) associated with a collection action or adverse credit rating. The more information the beneficiary provides, the less time it will take to determine the cause of his or her problem. The DCAO will research the beneficiary’s claim with the appropriate claims processor or other agency points of contact and provide the beneficiary with



a written resolution to the collection problem. The DCAO will notify the collection agency that action is being taken to resolve the issue.

TRICARE Claim Disputes

In the event you disagree with reimbursement rates, you may request a claim review (TRICARE allowable charge review). A claim review differs from an appeal, which is only for charges denied as “not covered” or not “medically necessary.”

The following subsections detail the appropriate types of review requests, time frames for submitting requests, contact information, and the information to include with requests. By following the rules and timelines for requesting reviews, you can help 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:

- allowed amount disputes
- charges denied as “Included in a paid service”
- charges denied as “Requested information not received”
- claim denied as “Provider not authorized”
- ClaimCheck® denials
- coding issues
- cost-share and deductible issues
- eligibility denials
- other health insurance issues
- penalties for no authorization

Point of service (POS) option disputes (Exception: point of service for emergency services is appealable)

- third party liability issues
- timely filing limit denials
- wrong procedure code

ClaimCheck®, is a registered trademark of McKesson Corporation. All rights reserved.

How to Request a Claim Review

Your request must be postmarked or received by Health Net within 90 calendar days of the date on the beneficiary’s TRICARE EOB or the TRICARE Summary Payment Voucher/Remit.

Include the following:

- letter with the reason for requesting the claim review
- copy of the claim if available
- copy of the EOB or TRICARE Summary Payment Voucher/Remit
- supporting medical records
- any new information that was not submitted with the original claim

Fax the request to **1-888-432-7077**.

Network Provider Disputes Relating to Contractual Reimbursement Amount

Network providers who believe they have been reimbursed at less than the agreed-upon rate should fax a request for review to **1-888-244-4025**.

Submit the request for review within 90 calendar days of the date of the TRICARE EOB or TRICARE Summary Payment Voucher/Remit relating to the alleged underpayment. The request should identify, in detail, why you believe the reimbursement amount is incorrect. Failure to submit a request for review within these parameters and within this time frame constitutes a waiver of any such claim.

Appeals and Administrative Reviews of Claim Denials

The following are considered appealable issues:

- claims denied because the service is not covered under TRICARE or exceeds policy limitations/coverage criteria
- claims denied as not medically necessary
- claims for assistant surgeon charges denied by ClaimCheck
- claims processed as POS only when the reason for dispute is that the service was for emergency care



Note: Network providers must hold the beneficiary harmless for non-covered care. Under the “hold harmless” policy, the beneficiary has no financial liability and, therefore, has no appeal rights. However, if the beneficiary has waived his or her hold harmless rights, the beneficiary may be financially liable and further appeal rights may be offered. Refer to the “Informing Beneficiaries about Non-Covered Services” and “TRICARE’s Hold Harmless Policy” in the *Important Provider Information* section of this handbook.

Appeal and administrative review requests must be postmarked or received **within 90 calendar days** of the date of the denial. For TRICARE purposes, a postmark is a cancellation mark issued by the U.S. Postal Service. If the postmark on the envelope is not legible, the date of receipt is deemed to be the date of the filing.

Providers may mail appeal and review requests to:

Health Net Federal Services, LLC

TRICARE Claims Appeal
P.O. Box 105266
Atlanta, GA 30348-5266

For more detailed information about the appeals process, visit the Health Net Claim Appeals page.

When filing appeals, keep the following in mind:

- all appeal/administrative review requests must be in writing and must be signed
- all appeal/administrative review requests must state the issue in dispute
- be certain to include a copy of the initial denial (EOB/provider remittance advice) and any additional documentation in support of the appeal

Additionally, provide the following information with your appeal:

- sponsor’s SSN
- beneficiary’s/patient’s name
- date(s) of service
- provider’s address, telephone/fax numbers and e-mail address, if available
- statement of the facts of the request

Appeals must be requested by an appropriate appealing party. A signed **Appointment of Representative for an Appeal** form may be required if applicable.

Who Can Appeal a Denied Claim?

- The patient may appeal, except if services were by a network provider. (Network providers cannot bill patients for non-covered services or services denied as not medically necessary.)
- The parent or legal guardian of a minor child may appeal, except if services were by a network provider. The child must be under age 18 (under age 21 for Pennsylvania) at the time the appeal is submitted. A network provider can appeal services they performed.
- A non-network provider can appeal services he or she performed if he or she accepted assignment on the claim.
- Legally appointed representatives may appeal. Appeals submitted by anyone other than the above will not be accepted unless he or she has been appointed as a representative by power of attorney or by submitting an **Appointment of Representative for an Appeal** form.
- An attorney may submit an appeal if acting on behalf of an appropriate appealing party.





TRICARE Reimbursement Methodologies



Reimbursement rates and methodologies are subject to change per Department of Defense (DoD) guidelines. Refer to the [TRICARE Reimbursement Manual](#) on the TRICARE Management Activity (TMA) website for more details.

Reimbursement Limit

Payments made to network providers for medical services rendered to TRICARE beneficiaries will not exceed 100 percent of the **TRICARE allowable charge**. All reimbursement methodologies discussed in this chapter are impacted by a network provider's negotiated discount rate. A network provider will not receive 100 percent of the TRICARE allowable charge if they have a negotiated discount. Nonparticipating, non-network providers may not bill TRICARE beneficiaries more than 115 percent of the TRICARE allowable charge.

If you believe a claim has been incorrectly denied, you should follow the allowable charge review process explained in "TRICARE Claim Disputes" in the *Claims Processing and Billing Information* section of this handbook.

TRICARE CHAMPUS Maximum Allowable Charge

The TRICARE CHAMPUS Maximum Allowable Charge (CMAC) is the maximum amount TRICARE will reimburse for nationally established procedure coding (that is, codes for professional services). Updated CMAC rates based on site of service are available on the [TMA](#) website. Periodic CMAC changes apply to both network and non-network providers.

Site-of-Service Pricing Categories

TRICARE CMAC changes vary per TMA's discretion.

The following represent the four categories of providers used for reimbursement:

Category one: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons certified nurse midwives, and audiologists provided in a facility

including hospitals (both inpatient and outpatient and billed with the appropriate revenue and procedure code for the outpatient department where the services were rendered), residential treatment centers (RTCs), ambulances, hospices, military treatment facilities (MTFs), behavioral health facilities, community mental health centers (CMHCs), skilled nursing facilities (SNFs), ambulatory surgical centers (ASCs), etc.

Category two: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, certified nurse mid-wives, and audiologists provided in a non-facility including provider offices, home settings and all other non-facility settings. The non-facility CMAC rate applies to occupational therapy (OT), physical therapy (PT) and speech therapy (ST) regardless of the setting.

Category three: Services of all other providers not found in category one, provided in a facility including hospitals (both inpatient and outpatient and billed with the appropriate revenue code for the outpatient department where the services were rendered), RTCs, ambulances, hospices, MTFs, behavioral health facilities, CMHCs, SNFs, ASCs, etc.

Category four: Services, of all other providers not found in category two, provided in a non-facility including provider offices, home settings and all other non-facility settings.

TRICARE CHAMPUS Maximum Allowable Charge Calculator

To use the TRICARE CMAC calculator visit the [TMA](#) website and follow the online prompts. For CMAC rates from previous years, use the applicable CPT® code.

Questions about using this application can be sent to Webmaster-CMAC@tma.osd.mil.



TRICARE-Allowable Charge

The TRICARE allowable charge is the maximum amount TRICARE will authorize for TRICARE-covered medical and other services furnished in an inpatient or outpatient setting. The TRICARE allowable charge is normally the lesser of: (a) the actual billed charge; (b) the CMAC or (c) the prevailing charge (or amount derived from a conversion factor) made for a given procedure, adjusted to reflect local economic conditions as detailed in the [TRICARE Reimbursement Manual](#).

For example:

- If the TRICARE allowable charge for a service is \$90 and the billed charge is \$50, the TRICARE allowable charge becomes \$50 (the lesser of the two charges).
- If the TRICARE allowable charge for a service is \$90, and the billed charge is \$100, TRICARE will allow \$90 (the lesser of the two charges).
- In the case of inpatient hospital payments, the specific hospital reimbursement method applies (for example, diagnosis-related group [DRG] rate or behavioral health per diem is the TRICARE allowable charge regardless of the billed amount, unless otherwise stated in the provider's contract).
- In the case of outpatient hospital claims subject to the TRICARE Outpatient Prospective Payment System (OPPS), services will be subject to OPPS Ambulatory Payment Classifications (APCs), where applicable.

Note: A network provider acknowledges and agrees that the maximum amount reimbursed for services provided by the network provider under a TRICARE Provider Agreement is prescribed by TRICARE/CHAMPUS regulations as published in the Federal Register, and regardless of what is stated in the TRICARE Provider Agreement and/or the Compensation Schedule, the network provider shall not receive or accept any reimbursement in excess of the TRICARE CHAMPUS Maximum Allowable Charge, as determined by the category or type of provider the network provider was, per the TRICARE/CHAMPUS regulations, at the time covered services were rendered.

State Prevailing Rates

State prevailing rates are established for codes that have no current available CMAC pricing. Prevailing rates are those charges that fall within the range of charges most frequently used in a state for a particular procedure or service. When no TRICARE allowable charge is available, a prevailing charge is developed for the state in which the service or procedure is provided.

In lieu of a specific exception, prevailing profiles are developed on:

- a statewide basis (localities within states are not used, nor are prevailing profiles developed for any area larger than individual states)
- a non-specialty basis

Prevailing profiles are developed using a minimum of eight claims submitted for reimbursement to TRICARE. All actual charges billed for the service are put in ascending order, and the lowest charge (in the array) that is high enough to include 80 percent of the cumulative charges (number of claims billed) becomes the prevailing charge. For more details, refer to the [TRICARE Reimbursement Manual, Ch. 5, Sec. 1](#).

Per TRICARE policy, all state prevailing rates established after the implementation of CMAC in May 1992, were frozen at the 1992 level or from the time a state prevailing was established for any new codes released by TRICARE Management Activity. Effective with the 2012 CMAC update, policy directs an annual update will be performed on all current **state prevailing rates**. For more details, refer to the [TRICARE Reimbursement Manual, Ch. 5, Sec. 1 and Sec 3](#).

If TRICARE does not receive eight claims for a particular procedure, TRICARE will determine the prevailing rate by using information about the volume of business done by various providers or suppliers within the TRICARE North Region or through available price lists and supply catalogs.

Anesthesia Claims and Reimbursement

Professional anesthesia claims must be submitted on a Centers for Medicare & Medicaid Services (CMS)-1500 form, using the applicable CPT anesthesia codes. If applicable, bill the claim with the appropriate physical status (P) modifier and, if appropriate, other optional modifiers. An anesthesia claim must specify who provided



the anesthesia. In cases where a portion of the anesthesia service is provided by an anesthesiologist and a nurse anesthetist performs the remainder, the claim must identify exactly which provider performed each service, and may include modifiers to make this distinction.

Anesthesia Rates

TRICARE calculates anesthesia reimbursement rates using the number of time units, the Medicare relative value units (RVUs), and the anesthesia conversion factor.

Calculating Anesthesia Reimbursement

The following formula is used to calculate the TRICARE anesthesia reimbursement:

$$\begin{array}{r} \text{(Time Units + RVUs)} \\ \times \\ \text{Conversion Factor} \end{array}$$

Base unit – TRICARE anesthesia reimbursement is determined by calculating a base unit, derived from the Medicare Anesthesia Relative Value Guide, plus an amount for each unit of time the anesthesiologist is in attendance (in the beneficiary's presence). A base unit includes reimbursement for:

- preoperative examination of the beneficiary
- administration of fluids and/or blood products incident to anesthesia care
- interpretation of non-invasive monitoring (for example, electrocardiogram, temperature, blood pressure, oximetry, capnography, and mass spectrometry)
- determination of required dosage/method of anesthesia
- induction of anesthesia
- follow-up care for possible postoperative effects of anesthesia on the beneficiary

Services **not** included in the base value include: placement of arterial, central venous and pulmonary artery catheters and the use of transesophageal echocardiography. When multiple surgeries are performed, only the RVUs for the primary surgical procedure are considered, while the time units should include the entire surgical session.

Note: This does not apply to continuous epidural analgesia.

Time unit – Time units are measured in 15-minute increments and any fraction of a unit is considered a whole unit. Anesthesia time starts when the anesthesiologist begins to prepare the beneficiary for anesthesia care in the operating room or in an equivalent area. It ends when the anesthesiologist is no longer in personal attendance and the beneficiary may be safely placed under post-anesthesia supervision. On the CMS-1500 the DUTs in column 24G should always be 1 unit per procedure. Please indicate the start and stop times of the anesthesia administration on the CMS-1500. For EDI claims, please indicate the total anesthesia minutes in loop and segment 2400/SV104.

Conversion factor – The sum of the time units and RVUs is multiplied by a conversion factor. Conversion factors 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, refer to the [TRICARE Reimbursement Manual](#).

Anesthesia Procedure Pricing Calculator

For an anesthesia rate calculator, visit the [TMA](#) website and follow the online prompts.

Ambulatory Surgery Grouper Rates

Only non-OPPS providers are reimbursed under this methodology. Hospital-based surgery procedures are reimbursed under OPPS (for hospitals that are subject to OPPS).

Ambulatory surgery facility payments fall into one of 11 TRICARE grouper rates. All procedures identified by TMA for reimbursement under this methodology can be found in the [TRICARE Reimbursement Manual, Ch. 9, Sec. 1](#). TRICARE payment rates established under this system apply only to the facility charges for ambulatory surgery. Ambulatory surgery providers may view reimbursements, ambulatory surgery rates and grouper assignments at the [TMA](#) website.

Ambulatory Surgery Center Charges

All hospitals or freestanding ambulatory surgery centers (ASCs) must submit claims for surgery procedures on a UB-04 claim form. Hospital-based ASC providers must use Type of Bill 13X.



Multiple Procedures

Multiple ambulatory surgeries are processed according to multiple surgery guidelines. Reimbursement is based on the sum of the following two amounts:

- One hundred percent of the payment amount for the procedure subject to discounting with the highest TRICARE allowable charge (only one procedure on an outpatient episode is paid at 100 percent) unless the specific procedure is listed in the CPT, 4th Edition (CPT-4) as a modifier 51 exempt or add on code.
- Fifty percent of the TRICARE allowable charge for each of the other procedures subject to discounting performed during the same session.

No reimbursement is made for incidental procedures performed during the same operative session in which other covered surgical procedures were performed. An incidental surgical procedure is one that is performed at the same time as a more complex primary surgical procedure. Providers will not be reimbursed for incidental procedures. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure. Incidental procedures will only be reimbursed if required for surgical management of multiple traumas or if involving a major body system different from the one served by the primary surgery.

For freestanding ASCs and non-OPPS hospitals, in some instances of multiple ambulatory surgeries, one procedure may be on the TMA ASC procedure list, and one may not.

Process these claims as follows:

- If the procedure on the ASC list has the highest TRICARE allowable charge amount, the claim will process under the multiple ambulatory surgery guidelines, as noted previously.
- If the billed charge for the procedure is not on the ASC list and is the highest TRICARE allowable charge amount, the claim will not be reimbursed as an ASC claim. The procedure not on the ASC list (the highest TRICARE allowed charge) will be reimbursed at 100 percent and the ASC-approved procedure will be reimbursed at 50 percent, as noted previously. Facility

charges for procedures that are not on the ASC list are reimbursed at the billed charge or **state prevailing rates** less any contracted discounts.

Note: There are specific procedures that may not discount even if billed as a multiple surgery session. See CPT-4 under “modifier 51 exempt” or “add on” codes.

Ambulatory Surgery Rate Lookup Tool

To find ambulatory surgery rates, visit the **TMA Ambulatory Surgery** page and follow the online prompts.

Diagnosis-Related Group Reimbursement

Diagnosis-related group reimbursement (DRG) 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). A grouper program classifies each case into the appropriate DRG.

The grouper used for the TRICARE DRG-based payment system is the same as the Medicare grouper with some modifications, such as neonate DRGs, age-specific conditions and mental health DRGs. Refer to the **TRICARE Reimbursement Manual** for more details.

TRICARE uses the TRICARE Severity DRG payment system, which is modeled on the Medical Severity DRG payment system.

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. Present of admission 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 **TMA TRICARE/CHAMPUS DRG-Based Payment System** page.



Any claim that does not report a valid POA indicator for each diagnosis on the claim will be denied. The five valid POA codes are described in Figure 8.1.

Present on Admission Code Descriptions Figure 8.1

POA Code	Description
Y	Indicates that the condition was present on admission.
W	Affirms that the provider has determined based on data and clinical judgment it is not possible to document when the onset of the condition occurred.
N	Indicates that the condition was not present on admission.
U	Indicates the documentation is insufficient to determine if the condition was present at the time of admission.
	Exempt from POA reporting. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines.

Note: The number “1” is no longer valid on claims submitted under version HIPAA 5010, effective as of June 30, 2012. The POA field should be left blank for codes exempt from POA reporting.

The following hospitals are exempt from POA reporting for TRICARE:

- critical access hospitals (CAHs)
- long-term care hospitals
- cancer hospitals
- children’s inpatient hospitals
- inpatient rehabilitation hospitals
- psychiatric hospitals and psychiatric units
- sole community hospitals (SCHs)
- Department of Veterans Affairs hospitals

Diagnosis-Related Group Calculator

The DRG calculator is available at the [TMA](#) website.

You can locate the indirect medical education (IDME) factor (for teaching hospitals only) and wage index information

using the “Wage Index and IDME Factors File” that are also available on the [TMA](#) website. If a hospital is not listed in the “Wage Index and IDME Factors File,” use the ZIP to Wage Index File to obtain the wage index for that area by ZIP code.

Capital and Direct Medical Education Cost Reimbursement

Facilities may request capital and direct medical educational cost reimbursement. Capital items (for example, property, structures and equipment) usually cost more than \$500 and can depreciate under tax laws. Direct medical education is defined as formally organized or planned programs of study in which providers engage to enhance the quality of care at an institution.

Submit requests for reimbursement under capital and direct medical education costs to Health Net/PGBA, LLC (PGBA) on or before the last day of the twelfth month following the close of the hospital’s cost-reporting period. The request shall cover the one-year period corresponding to the hospital’s Medicare cost-reporting period. This applies to hospitals (except children’s hospitals) subject to the TRICARE DRG-based system.

When submitting initial requests for capital and direct medical education reimbursement, 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 active duty service members in units subject to DRG-based payment
- total allowable capital costs (must correspond with the applicable pages from the Medicare cost report)



- total allowable direct medical education costs (must correspond with the applicable pages from the Medicare cost report)
- total full-time equivalents for residents and interns
- total inpatient beds as of the end of the cost-reporting period
- title of official signing the report
- reporting date

The provider's office manager (or administrator) must include a statement certifying that any changes resulting from a Medicare audit will be reported to Health Net/PGBA within 30 days of the hospital's notification of the change. A failure to promptly submit an amended Medicare cost report is considered a misrepresentation of the cost report information and can be considered fraudulent.

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 percent 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 (PhDs, social workers, counselors, certified psychiatric nurse specialists, and marriage and family therapists) are not eligible.

Providers can determine if they are in an HPSA by accessing the U.S. Department of Health and Human Services, Health Resources and Services Administration's [HPSA search tool](#). The Centers for Medicare and Medicaid Services (CMS) has HPSA designations along with bonus payment information at the [CMS](#) website.

How Bonus Payments Are Calculated

For providers who are eligible and located in an HPSA, Health Net's claims processor, PGBA, will calculate a quarterly 10 percent bonus payment from the total paid amount for TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Standard, and TRICARE Reserve Select

claims and the amount paid by the government on other health insurance claims.

Please keep in mind the following:

- When submitting a claim for bonus payment, providers must include the AQ CPT® modifier in Column 24D of the CMS-1500 claim form.
- For CPT codes with multiple modifiers, place the AQ modifier last.
- If you are eligible for a bonus payment but do not submit claims with the appropriate modifier, you will not receive the bonus payment from TRICARE.
- There are no retroactive payments, adjustments or appeals for obtaining a bonus payment, so be sure to include the bonus payment modifier with your initial claims submission if you are eligible.
- When calculating bonus payment for services that contain both a professional and technical component, only the professional component will be used.

Note: Although Medicare no longer requires the use of modifiers, TRICARE still requires their use. If you submit claims without the modifier, you cannot receive a bonus payment.

Skilled Nursing Facility Pricing

Skilled nursing facilities (SNFs) are paid using the Medicare PPS and consolidated billing. Skilled nursing facility PPS rates cover all routine, ancillary and capital costs of covered SNF services. Skilled nursing facilities are required to perform resident assessments using the minimum data set. Skilled nursing facility admissions require an prior authorization when TRICARE is the primary payer.

SNF admissions for children under age 10 and critical access hospital swing beds are exempt from skilled nursing facility PPS and are reimbursed based on DRG or contracted rates.

For more information about skilled nursing facility PPS, refer to the [TRICARE Reimbursement Manual, Ch. 8, Sec. 2](#).



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-care episodes, allowing HHAs to receive two payments of 60 percent and 40 percent, 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 Health Net and must be renewed every 60 days. 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.

Tips for Filing a Request for Anticipated Payment

To file a request for anticipated payment (RAP):

- The bill type in Form Locator (FL) 4 of the UB-04 is always 322 or 332.
- The "To" date and the "From" date in FL 6 must be the same and must match the date in FL 45.
- FL 39 must contain code 61 and the Core-Based Statistical Area code of the beneficiary's residential address.
- There must be only one line on the RAP, and it must contain revenue code 023 and 0 dollars. On this line, FL 44 must contain the Health Insurance PPS code. The quantity in FL 46 must be 0 or 1.
- FL 63 must contain the authorization code assigned by the Outcome Assessment Information Set.

Tips for a Final Claim

- Network home health care providers must submit TRICARE claims electronically. The bill type in FL 4 must always be 329 or 339.
- In addition to the blocks noted for the RAP above, each actual service performed with the appropriate revenue code must be listed on the claim form lines. The claim must contain a

minimum of five lines to be processed as a final request for anticipated payment. The dates in FL 6 must be a range from the first day of the episode, plus 59 days. Dates on all of the lines must fall between the dates in FL 6.

Exceptions

Beneficiaries enrolled in the Custodial Care Transition Program (CCTP) are exempt from the new claim filing rules and providers treating them may continue fee-for-service billing. For details about beneficiaries grandfathered under the CCTP, refer to the [TRICARE Policy Manual, Ch. 8, Sec. 15.1](#).

Durable Medical Equipment, Prosthetics, Orthotics and Supplies Pricing

Durable medical equipment prosthetics, orthotics and supplies (DMEPOS) prices are established by using Medicare fee schedules, reasonable charges, state prevailing rates, and average wholesale pricing (AWP). Most durable medical equipment (DME) payments are based on a fee schedule established for each DMEPOS item. The services and/or supplies are coded using CMS Healthcare Common Procedure Coding System (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.

Parenteral and enteral nutrition items and services and fees are also included with the DMEPOS schedule. Durable medical equipment prosthetics, orthotics, and supplies pricing information is available at the [TMA](#) website. DME prior authorization requirements are listed on [Health Net's](#) website.



Home Infusion Drug Pricing

Home infusion drugs are those drugs (including chemotherapy drugs) that cannot be taken orally and are administered in the home by other means: intramuscularly, subcutaneously, intravenously, or infused through a piece of durable medical equipment (DME). Durable medical equipment verification is not required.

Home infusion drugs are reimbursed the lesser of the billed amount or 95 percent of the AWP, as retrieved from the National Drug Data File (formerly the National Drug Blue Book). Home infusion drugs must be billed using an appropriate J, Q or S code along with a specific National Drug Code (NDC) for pricing.

Prior authorization is required for all beneficiaries except those with other health insurance. The prior authorization must be received before the initiation of the therapy in order to ensure medications are received from the correct TRICARE source and any required nursing visits are pre-approved. Services rendered without prior authorization may be ruled as non-covered benefits or may result in a payment penalty. When the provider initially certifies self or caretaker infusion, or injection is medically appropriate for either homebound or non-homebound beneficiaries, the beneficiary must receive education from a home health agency.

Nursing visits will be authorized by Health Net based on the type of services, homebound status of the beneficiary and classification of home health nursing provider. Homebound status for a beneficiary is determined by the provider.

The type of medication and length of administration will determine whether the home infusion/injection medication will be paid under the medical benefit or through the TRICARE pharmacy benefit.

Claims for home infusion will be identified by the place of service and the CMS HCPCS National Level II Medicare codes along with the specific NDC number of the administered drug.

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 provider to indicate one of the following:

- a service or procedure has both a professional and technical component
- a service or procedure was performed by more than one physician and/or in more than one location
- a service or procedure was provided more than once
- unusual events occurred during the service
- a procedure was terminated prior to completion
- Providers should use applicable modifiers that fit the description of the service and the claim will be processed accordingly – CPT and HCPCS publications contain lists of modifiers available for describing services

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 with 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

When billing for assistant surgeon services, please note:

- All assistant surgeon claims are subject to medical review and medical-necessity verification.
- Standby assistant surgeon services are not reimbursed when the assistant surgeon does not actively participate in the surgery.
- The PA or NP must actively assist the operating surgeon as an assistant surgeon and perform services that are authorized as a TRICARE benefit.



- When billing for a procedure or service performed by a PA, the supervising or employing physician must bill the procedure or service as a separately identified line item (for example, PA office visit) and use the PA's provider number.
- The supervising or employing physician of a PA must be a TRICARE- authorized provider.
- Supervising authorized providers who employ NPs may bill as noted for the PA, or the NP may bill on their own behalf and use their NP provider number for procedures or services they perform.

Providers should use the modifier that best describes the assistant surgeon services provided in Column 24D on the CMS-1500 claim form:

- Modifier 80 indicates the assistant surgeon provided services in a facility without a teaching program.
- Modifier 81 is used for "Minimum Assistant Surgeon" when the services are only required for a short period during the procedure.
- Modifier 82 is used by the assistant surgeon when a qualified resident surgeon is not available.

Note: Modifiers 80 and 81 are applicable modifiers to use; however, they will most likely wait for medical review to validate the medical necessity for surgical assistance and possibly have medical records 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 (for example, small community hospital).

Surgeon's Services for Multiple Surgeries

Multiple surgical procedures have specific reimbursement requirements. When multiple surgical procedures subject to discounting are performed, the primary procedure (i.e., the procedure subject to discounting with the highest TRICARE allowable charge) will be paid at 100 percent of the contracted rate. Any additional covered procedures performed during the same session will be allowed at 50 percent of the contracted rate.

An incidental surgical procedure is one that is performed at the same time as a more complex primary surgical procedure. However, the incidental procedure requires

fewer additional physician resources and/or is clinically integral to the performance of the primary procedure. Therefore, an incidental procedure will not be reimbursed unless it is required for surgical management of multiple traumas or if it involves a major body system different from the primary surgical service.

Hospice Pricing

Hospice programs are not eligible for TRICARE reimbursement unless they enter into an agreement with TRICARE. National Medicare hospice rates will be used for reimbursement of each of the following levels of care provided by, or under arrangement with, a Medicare-approved hospice program:

- routine home care
- continuous home care
- inpatient respite care
- general inpatient care

The national Medicare payment rates are designed to reimburse the hospice for the costs of all covered services related to treating the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice. The only amounts that will be allowed outside of the locally adjusted national payment rates and not considered hospice services will be for direct patient care services rendered by an independent attending physician.

When billing, hospices should keep in mind the following:

- Bill for physician charges/services (physicians under contract with the hospice program) on a UB-04 using revenue code 657 and the appropriate CPT codes.
- Payments for hospice-based physician services will be paid at 100 percent of the TRICARE allowable charge and will be subject to the hospice cap amount (calculated into the total hospice payments made during the cap period).
- Bill independent attending physician services or patient-care services rendered by a physician not under contract with or employed by the hospice on a CMS-1500 using the appropriate CPT codes. These services will be subject to standard TRICARE reimbursement and cost-sharing/ deductible provisions, and will not be included in the cap amount calculations.



The hospice will be reimbursed for the amount applicable to the type and intensity of the services furnished to the beneficiary on a particular day. Each level of care will be paid at the same rate, except for continuous home care, which will be reimbursed based on the number of hours of continuous care furnished to the beneficiary on a given day.

Reimbursement may be extended for routine and continuous hospice care provided to beneficiaries residing in a nursing home facility, that is, physician, nurse, social worker and home health aide visits to patients requiring palliative care for a terminal illness. TRICARE will not pay for the room and board charges of the nursing home.

Note: Continuous home care must be equal to or greater than eight hours per day, midnight to midnight, with at least 50 percent of care provided by licensed practical nursing or registered nursing staff. The rates will be adjusted for regional differences using appropriate Medicare area wage indexes.

Outpatient Prospective Payment System

The outpatient prospective payment system (OPPS) is the payment methodology used to reimburse 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 (for example, CAHs, cancer hospitals, and 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
- certain hospitals in Maryland that qualify for payment under the state's cost containment waiver

- hospitals located outside one of the 50 United States, Washington, D.C. and Puerto Rico
- Indian Health Service hospitals that provide outpatient services

Specialty care providers, including:

- cancer and children's hospitals
- community mental health centers
- comprehensive outpatient rehabilitation facilities
- Department of Veterans Affairs hospitals
- freestanding ASCs
- freestanding birthing centers
- freestanding end-stage renal disease facilities
- freestanding partial hospitalization programs (PHPs) and substance use disorder rehabilitation facilities (SUDRFs)
- home health agencies
- hospice programs
- other corporate services providers (for example, freestanding cardiac catheterization and sleep disorder diagnostic centers)
- skilled nursing facilities
- residential treatment centers

For more information on OPPS implementation, refer to the [TRICARE Reimbursement Manual, Ch. 13](#); visit The [TMA Outpatient Prospective Payment System](#) page; or contact Health Net at **1-877-TRICARE (1-877-874-2273)**.

As with Medicare, payment will not be made for procedures performed in an outpatient setting which are designated as requiring inpatient care. View the list of "Inpatient Only" procedures at the [TMA Inpatient Procedures](#) page.

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 four-year period. The four-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 three-year period, with reductions in each transition year.

Figure 8.2 shows the TTPA percentages for APC codes 604–609 and 613–616 during the four-year network hospital and three-year non-network hospital transition periods.

TTPA Percentages for APC Codes 604–609 and 613–616 *Figure 8.2*

Transition Period	Network ¹		Non-Network ²	
	ER	Hospital Clinic	ER	Hospital Clinic
Year 1 (5/1/09 – 4/30/10)	200%	175%	140%	140%
Year 2 (5/1/10 – 4/30/11)	175%	150%	125%	125%
Year 3 (5/1/11 – 4/30/12)	150%	130%	110%	110%
Year 4 (5/1/12 – 4/30/13)	130%	115%	100%	100%
Year 5 (5/1/13 – 4/30/14)	100%	100%	100%	100%

¹ The transition period for network hospitals is four years. In year five, TRICARE's payment level will be the same as Medicare's (100%).

² The transition period for non-network hospitals is three years. In year four, TRICARE's payment level will be the same as Medicare's (100%).

Temporary Military Contingency Payment Adjustments

Network hospitals that have received OPSS payments of \$1.5 million or more for care provided to ADSMs and ADFMs during an OPSS year (May 1–April 30) may be given a Temporary Military Contingency Payment Adjustment (TMCPA). Hospitals that qualify for a TMCPA may receive a 10 percent increase in the total OPSS payments for the fourth year of OPSS May 1, 2012 to April 30, 2013.

Partial Hospitalization Program Claims

TRICARE reimburses outpatient claims for PHP services for hospital-based and PHPs (psychiatric and SUDRFs) subject to TRICARE prior authorization requirements.

TRICARE reimburses; under the Outpatient Prospective Payment System (OPPS), a national per diem ambulatory payment classification (APC) payment. The OPPS is mandatory for both network and non-network providers. TRICARE follows Medicare's reimbursement methodology, which uses two separate APC payment rates to reimburse hospital-based OPPS PHP claims. Visit the [TMA Outpatient Prospective Payment System](#) page for current APCs and rates.

When billing hospital-based PHP care under OPPS,

1. Report PHP services on a UB-04 claim form
2. List the appropriate HCPCS and revenue codes separately for each service date
3. The bill type must be 013X
4. Condition code 41 must be present on the claim
5. A behavioral health primary diagnosis is needed
6. A minimum of three units of service per day

For more detail about PHP services under TRICARE OPPS refer to the [TRICARE Reimbursement Manual, Ch. 13, Sec. 2](#).

TRICARE also continues to reimburse free-standing PHP (Non OPPS) claims. Payment continues to be under the current TRICARE regional per diem rate schedule. Bill PHP care on UB-04 forms with a minimum of three units of service per day and use the following codes:

Revenue code 912

- Psychiatric partial hospitalization – all-inclusive per diem payment of three to five hours (half day); or
- Chemical dependency partial hospitalization – all-inclusive per diem payment of three to five hours (half day)

Revenue code 913

- Psychiatric partial hospitalization – all-inclusive per diem payment of six or more hours (full day); or
- Chemical dependency partial hospitalization – all inclusive per diem payment of six or more hours (full day)



Note: Revenue codes must be billed separately for each date of service.

For more information about PHP services in a Non OPPS facility, refer to the *TRICARE Policy Manual, Ch. 7, Sec. 3.6*.

For both OPPS and Non OPPS PHP programs:

- Services that may be billed separately:
 - TRICARE states physicians, clinical psychologists, Clinical Nurse Specialists (CBSs), Nurse Practitioners (NPs) and Physician Assistants (PAs) can bill separately for their professional services.
- Services included in the PHP payment:
 - TRICARE's reimbursement includes the provider's overhead costs, support staff, and those services furnished by clinical social workers, occupational therapists and alcohol and addiction counselors.

Updates to TRICARE Rates and Weights

Reimbursement rates and methodologies are subject to change per Department of Defense (DoD) guidelines. TRICARE rates are subject to change on at least an annual basis. Rate changes are usually effective on the dates listed in Figure 8.3.

The DoD adjusted the TRICARE reimbursement rates to mirror Medicare's levels. Updated rates and weights are available at the [TMA](#) website.

TRICARE Rates Update Schedule

Figure 8.3

Update Frequency	Rates Scheduled to Change
Variable at TMA's discretion	CMAC (may be adjusted quarterly) Anesthesia Injectables and immunizations
April 1	Birthing centers
October 1	DRG Residential treatment centers Behavioral health per diem SNF PPS (may be adjusted quarterly) Inpatient hospital copayments and cost-shares
November 1	Ambulatory surgery grouper
Quarterly	(January, April, July, October) DMEPOS Home health PPS OPPS
December 1	CAH



Provider Tools



Frequently Asked Questions

What is a TRICARE Prime service area?

A TRICARE Prime service area (PSA) is a grouping of ZIP codes in which TRICARE Prime is available. Per government specifications, a PSA includes all ZIP codes lying within or intersected by the 40-mile radius around designated military treatment facilities (MTFs) or other areas with a high concentration of TRICARE beneficiaries as a result of past Base Realignment and Closure (BRAC) actions.

Who determines TRICARE reimbursement rates?

Congress passed the Defense Appropriations Act, which established the uniform payment system for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), called the TRICARE CHAMPUS maximum allowable charge (CMAC). When TRICARE was implemented, the TRICARE Enabling Statute (Title 10, United States Code, Section 1079[h][1]) gave the secretary of defense the authority to set the reimbursement rates for health care services provided to TRICARE beneficiaries. Those rates are set in accordance with the same reimbursement rules that apply to payments for similar services under Medicare (Title XVIII of the Social Security Act [Title 42, United States Code, Section 1395]). Refer to the *TRICARE Reimbursement Methodologies* section of this handbook for more information. See "Glossary of Terms" later in this section for more information about CMAC versus TRICARE allowable charges.

What types of procedures require prior authorization?

Procedures that require prior authorization vary by beneficiary type. Refer to the *Health Care Management and Administration* section of this handbook for more information about the rules for prior authorization and how to obtain a list of procedures requiring prior authorization. Access the

Health Net Federal Services, LLC (Health Net) [Prior Authorization, Referral and Benefit Tool](#) to determine current prior authorization requirements.

Does TRICARE provide case management?

Health Net offers case management for beneficiaries with complex medical conditions. See the *Health Care Management and Administration* section for more information.

How are maternity patients managed?

Military medicine focuses on family-centered care before, during and after childbirth. Military treatment facilities in the North Region are committed to being responsive to maternity patients and flexible to their needs. They offer:

- an extended military "family" that is knowledgeable about the separation aspects of military life
- family-centered care so military families get the best possible personalized, coordinated maternity care

Expectant mothers are encouraged to visit the [TMA](#) website when deciding where to obtain maternity care. Refer to the *Medical Coverage* section of this handbook for details on maternity care coverage.

Does TRICARE have a mail order pharmacy program?

Yes. The TRICARE Pharmacy Home Delivery program is managed by Express Scripts. Visit the [Express Scripts](#) website or call Express Scripts at **1-877-363-1303** for more information.



Does TRICARE offer any programs for persons with disabilities?

Yes. The TRICARE Extended Care Health Option (ECHO) provides additional benefits to certain beneficiaries. See details about TRICARE ECHO in the *TRICARE Program Options* section of this handbook.

Does TRICARE have any contracted laboratory services?

Health Net maintains a network of laboratory services in the North Region, which you can view using the [Network Provider Directory](#) at the Health Net website. Please direct TRICARE beneficiaries to one of the contracted laboratories. When submitting a requisition for a laboratory procedure, please include the appropriate diagnosis code. Make sure the code is specific and consistent with services ordered. Otherwise, the claim will be denied.

How does TRICARE define an emergency?

An emergency is defined as a medical, maternity or behavioral health condition which would lead a layperson to believe a serious medical condition exists. This includes situations when the absence of immediate medical attention would result in a threat to life, limb or sight when a person has severe, painful symptoms that require immediate attention to relieve suffering; or when a person is an immediate risk to self or others.

Conditions requiring emergency care include loss of consciousness, shortness of breath, chest pain, uncontrolled bleeding, sudden or unexpected weakness or paralysis, poisoning, suicide attempt, and drug overdose. This also includes pregnancy-related medical emergencies involving sudden and unexpected medical complications that put the mother, baby or both at risk. TRICARE does not consider a delivery after the 34th week an emergency. **Note:** Care for accidental injury to the teeth alone or emergency room visits for dental pain are not covered by the TRICARE medical benefit.

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

How does TRICARE define urgent care?

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

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

If you are not available to provide a same-day appointment, you may refer the beneficiary to an urgent care center.

When is a prior authorization required for admission following emergency services? If a patient is admitted following emergency care, does that admission require prior authorization?

TRICARE providers must notify Health Net of all emergency room inpatient admission within 24 hours, or by the next business day, by faxing the patient's hospital admission record "face" sheet to Health Net at **1-877-809-8667**. The hospital admission record face sheet should include the beneficiary's demographic information, health plan information, name of the admitting physician and admitting diagnosis and date. If the hospital admission record face sheet is not available, providers can also complete an [Inpatient TRICARE Service/Request/Notification Form](#) and fax it to **1-877-809-8667**. Be sure to note on the form that the information is for an emergency inpatient admission notification.

Health Net reviews admission information and authorizes continued care, if necessary. Refer to the *Medical Coverage* section of this handbook for more information on urgent care and emergency services. Per [TRICARE Reimbursement Manual, Ch. 1 Sec 28](#), network and non-network providers, who submit claims for services without obtaining a prior authorization when required, will receive a 10 percent payment reduction during claims processing. For a network provider, the penalty may be greater than 10 percent depending on whether his or her network contract includes a higher penalty. These payment reduction penalties cannot be passed onto the beneficiary for payment. It is the provider's responsibility to obtain prior authorization when required.



Does TRICARE allow outpatient observation status?

Yes. Outpatient observation stays are reimbursed per the TRICARE outpatient prospective payment system (OPPS) methodology. A minimum of 8 hours or more of observation is required for consideration of payment. For details on how the TRICARE OPPS affects outpatient observation stays, refer to the **TRICARE Reimbursement Manual Ch. 13 Sec 2**. Outpatient observation stays are also reimbursed to non-OPPS facilities for up to 48 hours. If after 48 hours it becomes apparent the patient must continue as an inpatient, authorization for the inpatient admission must be obtained and medical necessity provided. For details on non-OPPS outpatient observation stays, refer to the **TRICARE Policy Manual, Ch. 2 Sec 2.3**. Health Net requires notification of all inpatient facility admission and discharge dates by the next business day following the admission and discharge. Health Net will conduct continued stay reviews for services listed in the TRICARE North Region Prior Authorization Requirement Table located at www.hnfs.com.

Do TRICARE Prime and TPR beneficiaries have coverage outside of this region?

Emergencies are covered for TRICARE Prime and TPR beneficiaries when traveling away from home, whether they are in or out of their TRICARE region. However, keep in mind:

- Health Net must be notified by the facility within 24 hours, or the next business day of an emergency inpatient hospital admission.
- Non-emergency care must be approved by the beneficiary's PCM and authorized by Health Net, when necessary, to ensure maximum TRICARE coverage.
- Routine, out-of-region care for all TRICARE Prime and TPR beneficiaries (excluding active duty service members) may be covered under the POS option.

Where does my office file TRICARE claims?

PGBA, LLC (PGBA), is Health Net's partner for claims processing. For more information, visit the **PGBA** website.

Note: TRICARE For Life claims are processed by Wisconsin Physicians Service. Refer to the *Claims Processing and Billing Information* section of this handbook for more information on filing claims. Claims for certain home infused or injected medications will be processed by Express Scripts Inc. but must first be coordinated through Health Net.

How do I order current TRICARE educational materials?

Providers can view the latest TRICARE materials, including manuals and *TRICARE Provider News* publications, on **Health Net's** website.





Acronyms

ABA	applied behavior analysis	DME	durable medical equipment
ADDP	Active Duty Dental Program	DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
ADFM	active duty family member	DoD	Department of Defense
ADSM	active duty service member	DRG	diagnosis-related group
APC	ambulatory patient classification	DTF	dental treatment facility
ASC	ambulatory surgery center	ECHO	Extended Care Health Option
BCAC	Beneficiary Counseling and Assistance Coordinator	EFMP	Exceptional Family Member Program
BRAC	Base Realignment and Closure	EFT	electronic funds transfer
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services (now called TRICARE)	EHHC	ECHO Home Health Care
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs (Veterans Affairs health care program for patients)	EIN	employee identification number
CCTP	Custodial Care Transition Program	EOB	explanation of benefits
CHCBP	Continued Health Care Benefit Program	ESRD	end-stage renal disease
CLR	clearly legible report	FDA	U.S. Food and Drug Administration
CMAC	CHAMPUS maximum allowable charge	HCFA	Health Care Financing Administration (now CMS)
CMN	Certificate of Medical Necessity	HCPCS	Healthcare Common Procedure Coding System
CMS	Centers for Medicare and Medicaid Services (formerly HCFA)	HIPAA	Health Insurance Portability and Accountability Act of 1996
COB	coordination of benefits	ICD-9	International Classification of Diseases, Ninth Revision
CPT®	Current Procedural Terminology CPT copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.	ID	identification
DCAO	Debt Collection Assistance Officer	IVR	interactive voice response
DEERS	Defense Enrollment Eligibility Reporting System	MCSC	managed care support contractor
		MHS	Military Health System
		MMSO	Military Medical Support Office
		MRI	magnetic resonance imaging



MTF	military treatment facility	TDP	TRICARE Dental Program
NAS	non-availability statement	TFL	TRICARE For Life
NATO	North Atlantic Treaty Organization	TMA	TRICARE Management Activity
NCI	National Cancer Institute	TPR	TRICARE Prime Remote
NDC	National Drug Code	TPRADFM	TRICARE Prime Remote for Active Duty Family Members
NOAA	National Oceanic and Atmospheric Administration	TRDP	TRICARE Retiree Dental Program
NPI	National Provider Identifier	TRO	TRICARE Regional Office
NQMC	National Quality Monitoring Contractor	TRR	TRICARE Retired Reserve
OHI	other health insurance	TRS	TRICARE Reserve Select
OPPS	outpatient prospective payment system	TSC	TRICARE Service Center
PCM	primary care manager	TYA	TRICARE Young Adult
PDTS	Pharmacy Data Transaction Service	USFHP	US Family Health Plan
PGBA	PGBA, LLC	USPHS	United States Public Health Service
PHP	partial hospitalization program	VA	Department of Veterans Affairs
PHS	Public Health Service	WPS	Wisconsin Physicians Service
POS	Point of service		
PPO	preferred provider organization (TRICARE Extra)		
PPS	prospective payment system		
RTC	residential treatment center		
SHCP	Supplemental Health Care Program		
SNF	skilled nursing facility		
SPOC	service point of contact		
SSN	Social Security number		
SUDRF	substance use disorder rehabilitation facility		
TAMP	Transitional Assistance Management Program		



Glossary of Terms

Abuse

The improper or excessive use of program benefits, resources, or services by a provider or beneficiary. Abuse can be either intentional or unintentional and can occur when:

- excessive or unnecessary services are used
- services are not appropriate for the beneficiary's condition
- a beneficiary uses an expired or voided identification card
- a more expensive treatment is rendered when a less expensive treatment would be as effective
- a provider or beneficiary files false or incorrect claims
- billing or charging does not conform to TRICARE requirements

Accepting assignment

Accepting assignment refers to when a provider agrees to accept the TRICARE allowable charge as payment in full. Network providers accept assignment on all claims and non-network providers may choose to accept assignment on a claim-by-claim basis.

Allowable charge review

An allowable charge review is a method by which a provider may request a review of a claim he or she deems was paid at an inappropriate level.

Appeals review

Method by which a non-network participating provider (that is, one who has accepted assignment) may request a review.

Authorization

See the definition for prior authorization.

Balance billing

When a provider bills a beneficiary for the difference between billed charges and the TRICARE allowable charge after TRICARE (and other health insurance) has paid everything it is going to pay. Providers are prohibited from balance billing.

Beneficiary

A beneficiary is a person who is eligible for TRICARE benefits. Beneficiaries include active duty family members and retired service members and their families. Other beneficiary categories are listed in the *TRICARE Eligibility* section of this handbook.

Beneficiary Counseling and Assistance Coordinators (BCACs)

Persons at military treatment facilities and TRICARE Regional Offices, who are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining medical care through TRICARE. Beneficiary Counseling and Assistance Coordinators were previously known as Health Benefits Advisors, or HBAs. To locate a BCAC, visit the [TRICARE Management Activity \(TMA\)](#) website.

Care coordination

An approach to care management using proactive methods to optimize health outcomes and reduce risks of future complications over a single, short-term (two to six weeks) episode of care. Prospective and concurrent reviews are used to identify current and future beneficiary needs.

Case management

A collaborative process normally associated with multiple episodes of health care intervention that assesses plans, implements, coordinates, monitors and evaluates options and services to meet a beneficiary's complex health needs. This is accomplished through communication and available resources that promote quality, cost-effective outcomes.

Catastrophic cap

The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given fiscal year (October 1–September 30). Point of service (POS) cost-shares and the POS deductible are not applied to the catastrophic cap.

Centers for Medicare and Medicaid Services

The federal agency that oversees all aspects of health care claims filing for Medicare (formerly known as the Health Care Financing Administration).



Certified provider

See the definition for TRICARE-authorized provider.

CHAMPUS Maximum Allowable Charge (CMAC)

The maximum amount TRICARE will cover for nationally established fees (that is, fees for professional services). CMAC is the TRICARE CHAMPUS Allowable Charge for covered services when appropriately applied to services priced under CMAC.

Circumvention

A term used to describe inappropriate medical practices or actions that result in unnecessary multiple admissions of an individual.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

The former health care program established to provide health care coverage for active duty family members and retirees and their family members. TRICARE was organized as a separate office under the Assistant Secretary of Defense and replaced CHAMPUS in 1994.

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

Civilian Health and Medical Program of the Department of Veterans Affairs is the federal health benefits program for family members of 100-percent totally and permanently disabled Veterans. To be eligible for CHAMPVA, the beneficiary cannot be eligible for TRICARE/CHAMPUS and he or she must be either the spouse or child of a Veteran who has been rated permanently and totally disabled for a service-connected disability by a VA regional office; the surviving spouse or child of a Veteran who died from a VA-rated service connected disability; the surviving spouse or child of a Veteran who was at the time of death rated permanently and totally disabled from a service connected disability or the surviving spouse or child of a military member who died in the line of duty, not due to misconduct (in most of these cases, these family members are eligible for TRICARE, not CHAMPVA). Civilian Health and Medical Program of the Department of Veterans Affairs is administered by the Department of Veterans Affairs (VA) and is not associated with the TRICARE program. For questions regarding CHAMPVA, call **1-800-733-8387** or e-mail **hac.inq@va.gov**.

ClaimCheck®

A customized, automated claims auditing system that verifies coding accuracy of professional claims.

ClaimCheck® is a registered trademark of McKesson Corporation. All rights reserved.

Clearly legible report (CLR)

For care referred from a military treatment facility to a civilian network provider, network providers must provide clearly legible reports. Clearly legible reports should include consultation and operative reports, notes regarding the episode of care and discharge summaries. They should be sent to the initiating provider within seven business days of the beneficiary's care. Visit the Health Net **Clearly Legible Reports** page for current information regarding submission guidelines for clearly legible reports.

CMS-1500

The National Uniform Claim Committee requires the use of the Centers for Medicare and Medicaid Services (CMS) Health Insurance Claim Form (version 08/05) to accommodate the reporting of the National Provider Identifier. The December 1990 version of the CMS-1500 claim form was discontinued and only the revised form is to be used after December 31, 2007. All rebilling of claims must use the revised form from January 1, 2008, forward, even though earlier submissions may have been on the December 1990 version of the CMS-1500 claim form.

Concurrent review

A review performed during the course of a beneficiary's inpatient admission with the purpose of validating the appropriateness of the admission, level of care, medical necessity, and quality of care, as well as the information provided during earlier reviews. Additional functions performed include screening for case management and identification of discharge planning needs. The review may be conducted by telephone or on site. Concurrent reviews are generally performed when TRICARE is the primary payer. Concurrent reviews are referred for medical director review when they indicate that criteria are not met.



Copayment

A fixed amount a TRICARE beneficiary pays for certain types of services based on the sponsor's status (active or retired) and the beneficiary's plan type (for example, TRICARE Prime, TRICARE Standard or TRICARE Reserve Select). A copayment is often called a copay. Copayment amounts are available on [Health Net's](#) website.

Corporate services provider

A class of TRICARE-authorized providers consisting of institutional-based or freestanding corporations and foundations that render professional ambulatory or in-home care and technical diagnostic procedures.

Cost-share

The percentage of the TRICARE allowable charges a beneficiary will pay under TRICARE Standard, TRICARE Reserve Select or TRICARE Retired Reserve. The cost-share depends on the sponsor's status – active duty or retired. Cost-share amounts are available on [Health Net's](#) website.

Note: Extended Care Health Option services also have cost-shares, regardless of the beneficiary's program option (including TRICARE Prime).

Covered services

The health care services, equipment and supplies that are covered under the TRICARE program.

Credentialing

The process that evaluates and subsequently allows providers to participate in the TRICARE network. This includes a review of the provider's training, educational degrees, licensure, practice history, etc.

Current Procedural Terminology (CPT®)

A systematic listing and coding of procedures and services performed by physicians. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physician is accurately identified. CPT Copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Deductible

The annual amount a TRICARE Standard, TRICARE Reserve Select or TRICARE Retired Reserve beneficiary must pay for covered outpatient benefits before TRICARE begins to share costs. TRICARE Prime and TRICARE Prime Remote (TPR) beneficiaries do not have an annual deductible, unless they are utilizing their point of service (POS) option. Deductible amounts are available on [Health Net's](#) website.

Defense base realignment and closure commission (BRAC) site

A military base that has been closed or targeted for closure by the government's BRAC.

Defense Enrollment Eligibility Reporting System (DEERS)

The DEERS database consists of uniformed services members (sponsors), family members, and others worldwide who are entitled under law to military benefits, including TRICARE. Beneficiaries are required to keep DEERS updated. Refer to the *TRICARE Eligibility* section for more information. The DEERS database is the official record system for TRICARE eligibility.

Designated provider (DP)

Under the US Family Health Plan (USFHP), DPs, formerly known as uniformed service treatment facilities, are selected civilian medical facilities around the U.S. assigned to provide care to eligible USFHP beneficiaries – including those who are age 65 and older – who live within the DP area. At these DPs, the USFHP provides TRICARE Prime benefits and cost-shares for eligible persons who enroll in USFHP, including those who are Medicare eligible.

Diagnosis-related group (DRG)

A reimbursement methodology used for inpatient care in some hospitals.

Discharge planning

A process that assesses requirements and the coordination of care for a beneficiary's timely discharge from an acute inpatient setting to a post-care environment without need for additional military treatment facility or network provider assistance.



Disease management

A prospective, disease-specific approach to improving health care outcomes by providing education to beneficiaries through non-physician practitioners who specialize in targeted diseases.

Department of Defense (DoD) Benefits Number (DBN)

The DBN is a unique identifying number on military identification (ID) cards of those eligible to receive military benefits. The DBN replaces Social Security numbers (SSNs) on military ID cards. The DBN is an 11-digit number that relates to TRICARE benefit eligibility. The DBN should be used for medical care and claims, as well as other military benefits such as the Commissary. This number is located on the back of the ID card, at the top and is different than the 10-digit DoD ID number also contained on the card. Visit the Health Net [Submitting Claims with New Beneficiary Identification Cards](#) page for more information.

Explanation of benefits (EOB)

A statement sent to a beneficiary and the provider showing that a claim was processed and indicates the amount paid to the provider.

Extended Care Health Option (ECHO)

The ECHO program is a supplemental program to the TRICARE basic program. It provides eligible active duty family members with additional financial resources for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the beneficiary's qualifying condition. Qualifying conditions may include moderate or severe mental retardation, a serious physical disability or an extraordinary physical or psychological condition such that the beneficiary is homebound.

Fraud

An instance in which the provider deliberately deceives the regional contractor in order to obtain payment for services not actually delivered or received, or when a beneficiary deliberately deceives the regional contractor to claim program eligibility.

Grievance

A grievance is a written complaint or concern from a TRICARE beneficiary or a provider on a non-appealable issue. Grievances address issues of perceived failure by any member of the health care delivery team – including TRICARE military providers, Health Net, or Health Net subcontractor personnel – to provide appropriate and timely health care services, access to care, quality of care, or level of care or service to which the beneficiary or provider feels they are entitled.

Healthcare Common Procedure Coding System (HCPCS)

A set of codes used by Medicare that describes services and procedures. The HCPCS codes include Current Procedural Terminology (CPT) codes for services not included in the normal CPT code list, such as durable medical equipment and ambulance service. While HCPCS is nationally defined, there is a provision for local use of certain codes.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

IPAA is a federal regulation implemented to improve portability and continuity of health insurance coverage in group and individual markets; safeguard protected health information, including regulation of electronic health information; combat waste, fraud and abuse in health insurance and health care delivery; promote use of medical savings accounts; improve access to long-term care services and coverage; and simplify the administration of health insurance and for other purposes. See also, HIPAA 5010 in the *Important Provider Information* section of this handbook.

Initial denial

A written decision or EOB denying a TRICARE claim, a request for prior authorization or a request by a provider for approval as an authorized TRICARE provider, on the basis that the service or provider does not meet TRICARE coverage criteria.

Managed care

A health care model under which an organization delivers health care to enrolled members and controls costs by closely supervising and reviewing the delivery of health care.



Managed care support contractor (MCSC)

A civilian health care partner of the Military Health System that administers TRICARE in one of the TRICARE regions. An MCSC (for example, Health Net) helps combine the services available at military treatment facilities (MTFs) with those offered by the TRICARE network of civilian hospitals and providers to meet the health care needs of TRICARE beneficiaries.

Medical emergency

TRICARE defines an emergency as a medical, maternity or behavioral health condition that would lead a layperson to believe a serious medical condition exists; the absence of immediate medical attention would result in a threat to life, limb or sight; when a person has severe, painful symptoms requiring immediate attention to relieve suffering; or when a person is at immediate risk to self or others.

Medically necessary

Appropriate and necessary treatment of the beneficiary's illness or injury according to accepted standards of medical practice and TRICARE policy. Medical necessity must be documented in clinical notes.

Military treatment facility (MTF)

An MTF is a medical facility (hospital, clinic, etc.) owned and operated by the uniformed services and usually located on or near a military base.

National Drug Code (NDC)

The U.S. Food and Drug Administration (FDA) requires companies engaged in the manufacture, preparation, propagation, compounding, or processing of a drug product to register with the FDA and provide a list of all drugs manufactured for commercial distribution. Drug products are identified and reported using a unique three-segment number called the NDC. National Drug Codes can be found on the [Drug Registration and Listing System](#) published by the FDA.

National Guard and Reserve

The National Guard and Reserve includes the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the Coast Guard Reserve.

National Provider Identifier (NPI)

The NPI is a 10-digit number used to identify providers in standard electronic transactions. It is a requirement of the Health Insurance Portability and Accountability Act of 1996.

Network provider

A network provider is a professional or institutional provider who has an agreement with Health Net or MHN to provide care at a contracted rate. A network provider agrees to file claims and handle other paperwork for TRICARE beneficiaries, and typically administers care to TRICARE Prime beneficiaries and those TRICARE Standard beneficiaries using TRICARE Extra (the preferred provider option). A network provider accepts the negotiated rate as payment in full for services rendered.

Non-availability statement

A non-availability statement (NAS) is a certification from a military treatment facility stating that a specific health care service or procedure cannot be provided.

Non-network provider

A non-network provider does not have an agreement with Health Net but is authorized to provide care to TRICARE beneficiaries. There are two types of non-network providers: participating and nonparticipating.

Nonparticipating provider

A nonparticipating provider is a TRICARE-authorized hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to TRICARE beneficiaries but who does not have an agreement and does not accept the TRICARE allowable charge or file claims for TRICARE beneficiaries. A nonparticipating provider may only charge up to 15 percent above the TRICARE allowable charge.

North Atlantic Treaty Organization (NATO) member

A member of a foreign NATO nation's armed forces who is on active duty and who, in connection with official duties, is stationed in or passing through the United States.



Other health insurance (OHI)

Any non-TRICARE health insurance that is not considered a supplement is considered OHI. This insurance is acquired through an employer, entitlement program or other source. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, State Victims of Crime Compensation Programs, the Indian Health Service or other programs or plans as identified by TRICARE Management Activity (TMA).

Outpatient prospective payment system (OPPS)

TRICARE OPPS is used to pay claims for hospital outpatient services. TRICARE OPPS is based on nationally established Ambulatory Payment Classification payment amounts and standardized for geographic wage differences that include operating and capital-related costs, which are directly related and integral to performing a procedure or furnishing a service in a hospital outpatient department.

Participating provider

A provider who has agreed to file claims for TRICARE beneficiaries, accept payment directly from TRICARE, and accept the TRICARE allowable charge as payment in full for services received. Non-network providers may participate on a claim-by-claim basis. Providers may seek payment of applicable copayments, cost-shares and deductibles from the beneficiary. Under the TRICARE outpatient prospective payment system, all hospitals that are Medicare-participating providers must, by law, also participate in TRICARE for inpatient and outpatient care.

Peer review organization

An organization charged with reviewing provider quality and medical necessity.

Per diem

A reimbursement methodology based on a per-day rate that is currently used for behavioral health institutions and partial hospitalization programs.

Point of service (POS)

An option that allows TRICARE Prime or TPR beneficiaries to obtain medically necessary services – inside or outside the TRICARE network – from someone other than their primary care manager (PCM) without first

obtaining a prior authorization or referral. Utilizing the **POS option** results in a deductible and higher out-of-pocket expenses for the beneficiary. The POS option does not apply to active duty service members.

Preferred provider organization (PPO)

A network of health care providers that provides services to patients at discounted rates or cost-shares. TRICARE Extra is considered a PPO option.

Primary care manager (PCM)

A TRICARE civilian network provider or military treatment facility (MTF) provider who provides primary care services to TRICARE Prime and TPR beneficiaries. A PCM is either selected by the beneficiary or assigned by an MTF Commander or his or her designated appointee. TRICARE Prime Remote beneficiaries may choose a non-network provider if a network provider is not available.

Prime service area (PSA)

A TRICARE Prime service area (PSA) is a grouping of ZIP codes in which TRICARE Prime is available. Per government specifications, a PSA includes all ZIP codes lying within or intersected by the 40-mile radius around designated military treatment facilities (MTFs) or other areas with a high concentration of TRICARE beneficiaries as a result of past Base Realignment and Closure (BRAC) actions.

Prior authorization

Prior authorizations are for certain services and/or procedures that require Health Net review and approval, prior to being provided. Some services and/or procedures that require prior authorization include certain behavioral health care, hospitalization, surgical, and therapeutic procedures.

Prospective review

A screening process used to evaluate the medical necessity and appropriateness of a treatment or service proposed. The review is prospective (before the care or service is performed) and criteria-based using InterQual. A registered nurse, physician assistant, behavioral health provider, or physician performs reviews.

Protected health information (PHI)

Protected health information is any individually identifiable health information that relates to a patient's past, present, or future physical or behavioral health and



related health care services. Protected health information may include demographics, documentation of symptoms, examination and test results, diagnoses, and treatments.

Reconsideration or appeal

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

Referral

The process of sending a patient to another professional provider (physician or behavioral health care provider) for consultation or a health care service that the referring source believes is necessary but is not prepared or qualified to provide. Referrals are required for most services for TRICARE Prime beneficiaries. Referrals are always required for active duty service members (ADSMs) (except in the case of an emergency) for services provided by a network provider, other than the PCM.

Region

A geographic area determined by the federal government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

Resource sharing agreement (RSA)

There are two types of RSAs:

- External RSAs are arrangements that allow military providers to render medical services to TRICARE beneficiaries in civilian network medical facilities.
- Internal RSAs are arrangements that allow network providers into the MTF system to render medical services to TRICARE beneficiaries.

Retrospective review

Review of a beneficiary's medical record that occurs after services have been rendered.

Right of first refusal

A military treatment facility (MTF) review of civilian prior authorizations and referrals received by Health Net to determine if the MTF is able to provide the requested services.

Social Security number (SSN)

An SSN is a number assigned by the federal government for the purposes of identifying a specific individual and taxpayer.

Split enrollment

Refers to multiple family members enrolled in TRICARE Prime under different TRICARE regions or MCSCs.

Sponsor

The sponsor is the ADSM or retiree through whom family members are eligible for TRICARE.

Supplemental Health Care Program (SHCP)

The SHCP is a program for eligible uniformed services members and other designated patients who require medical care that is not available at an MTF. Because services are not available at the MTF, these beneficiaries must be referred to a network provider.

Supplemental insurance

Supplemental insurance includes health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance plans, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

Tax Identification Number (TIN)

A TIN is a number assigned by the state in which a business or entity is operated that identifies it for filing and paying taxes related to the business or entity.

Transitional care

Transitional care is a program that is designed for all beneficiaries to ensure a coordinated approach takes place across the continuum of care.

Treatment plan

A treatment plan is a multidisciplinary care plan for each beneficiary in active case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, military resources, all funding options, treatment goals,



and assessment of the beneficiary environment. The plan is updated monthly and modified when appropriate. These plans are developed in collaboration with the attending physician and beneficiary or guardian.

TRICARE allowable charge

The **TRICARE allowable charge** (also called allowable charge) is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The TRICARE allowable charge is normally the lesser of: (a) the actual billed charge; (b) the CMAC or (c) the prevailing charge (or amount derived from a conversion factor) made for a given procedure, adjusted to reflect local economic conditions as detailed in the **TRICARE Reimbursement Manual**. For example, if the TRICARE allowable charge for a service is \$90 and the billed charge is \$50, TRICARE will pay \$50 (actual billed charge); if the billed charge is \$100, TRICARE will pay \$90 (the TRICARE allowable charge). In the case of inpatient hospital payments, the DRG rate is the TRICARE allowable charge, regardless of the billed amount. For network providers, the TRICARE allowable charge is the lesser of the contracted rate and the maximum amount TRICARE would authorize if the service had been furnished by a non-network participating provider.

TRICARE-authorized provider

A provider who meets TRICARE's licensing and certification requirements and has been authorized by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (such as laboratory and radiology providers), and pharmacies.

TRICARE Prime service area

See the definition for Prime service area.

UB-04

The CMS-1450 form (also known as the UB-92) has been replaced with the UB-04 form. The UB-04 form is used by hospitals and other institutional providers to bill government and commercial health plans; it must be used exclusively for institutional billing beginning January 1, 2008. The UB-04 data set accommodates the NPI and incorporates a number of other important changes and improvements. It is also HIPAA-compliant.

Urgent care

Urgent care is medically necessary treatment that is required for an illness or injury that would not result in further disability or death if not treated immediately. The illness or injury does require professional attention and should be treated within 24 hours to avoid development of a situation in which further complications could result if treatment is not received.

Forms

The following forms may be found at the **Health Net** website. If a form is not found on the website, contact a Health Net representative at **1-877-TRICARE (1-877-874-2273)**.

Appeals

Appointing a Representative for an Appeal

Applications

Eating Disorder Checklist

Residential Treatment Center Application

Authorizations

Authorization for Disclosure

Fax Separator Page

Inpatient TRICARE Service Request/Notification Form

Outpatient TRICARE Service Request/Notification Form

Inpatient Behavioral Health Waiver of Benefit Limit Request

Case management

Medical (Case) Management Referral

Claims

Statement of Personal Injury - Possible Third Party Liability



Grievances

Grievance

Letters of attestation

Abortion

Bariatric Surgery

Botulinum Toxin – Migraines

Botulinum Toxin – Upper Limb Spasticity

Circumcision

Cochlear Implants

Continuous Glucose Monitor

CT angiography

Diabetes Self-Management Training

Diabetic Shoes

Eye Glasses or Contacts

Hysterectomy

Insulin Pump

Lung Volume Reduction Surgery

Mastectomy (subcutaneous)

Nail Trimming

Otoplasty

Prophylactic Mastectomy

Prosthetic/Orthotic

Sleep Study

Synagis

Thoracic Sympathectomy

Ventricular Assist Device

Vertebroplasty or Balloon Kyphoplasty

Non-covered services

Request for Non-Covered Services

Other health insurance

Other Health Insurance Questionnaire

Patient rights

An Important Message from TRICARE (English)

An Important Message from TRICARE (Spanish)

Privacy

Grievance

Provider demographic updates

Provider Demographic Updates Form

Provider information form

Provider Information Form



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. 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 through 9d. If Box 11d is checked “Yes,” Boxes 9a and 9d must be completed. In addition, if there is another insurance carrier, the mailing address of that insurance carrier must be attached to the claim form.

BOX 9 Full name of person with 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 through Box 11c questions pertain to the sponsor.

BOX 11 Indicate policy group or Federal Employees Compensation Act (FECA) number (if applicable).

BOX 11a Sponsor’s date of birth and sex, if different than Box 3

BOX 11b 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 (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 26	Patient's account number (not required, but preferred)
BOX 21	Indicate at least one, and up to four, specific diagnosis codes.	BOX 27	Indicate whether provider accepts TRICARE assignment.
BOX 23	Prior authorization number	BOX 28	Total charges submitted on a claim
BOX 24A	Date of service	BOX 29	Amount paid by patient or other carrier
BOX 24B	Place of service	BOX 30	Amount due after other payments are applied (required if OHI)
BOX 24C	EMG (emergency) indicator	BOX 31	Authorized signature
BOX 24D	CPT/HCPCS procedure code with modifier, if applicable	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 24E	Diagnosis code reference number (pointer)	BOX 32a	NPI of the service facility location
BOX 24F	Charges for listed service	BOX 32b	Two-digit qualifier identifying the non-NPI number followed by the ID number (if necessary)
BOX 24G	Days or units for each line item	BOX 33	Physician's/Supplier's billing name, address, ZIP code, and phone number
BOX 24H	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) related services/ family planning response and appropriate reason code (if applicable)	BOX 33a	NPI of billing provider
BOX 24I	Qualifier identifying if the number is a non-NPI ID	BOX 33b	Two-digit qualifier identifying the non-NPI number followed by the ID number (if necessary)
BOX 24J	Rendering Provider ID number. Enter the non-NPI ID number in the shaded area. Enter the NPI number in the unshaded area.		
BOX 25	Physician's/Supplier's Tax Identification Number		



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

North Region Service Codes

Ambulance services:	F
Anesthesia:	4
Anesthesia exception:	6
Assistant at surgery:	0
Behavioral health:	C
Birthing center:	S
Consultation:	9
Darbepoetin:	6
Durable medical equipment:	G – Purchase; or H – Rental
Epoetin alpha injection codes:	6
Home infusion therapy:	G
Injections:	6
Maternity:	3
Medical:	6
Mobile Health Providers:	5
Neurology:	6 or P
Orthotic/prosthetic procedures:	G
Pathology/laboratory:	P or 8
Physical therapy:	D
Radiation oncology:	E
Radiation therapy:	P or E
Radiology:	P or 5
Supplies:	G
Surgery:	2



Uniform Bill Form (UB-04) Instructions

The following listing of UB-04 form locators is a summary of the Form Locator information.

- | | | | |
|----------------|---|------------------|---|
| FL 1 | Provider name, physical address and telephone number required | FL 14 | Type of admission. This code indicates priority of the admission. |
| FL 2 | Pay-to name and address required | FL 15 | Source of admission. This code indicates the source of admission or outpatient registration. |
| FL 3a | Patient control number | FL 16 | Discharge hour |
| FL 3b | Medical/health record number | FL 17 | Patient status. This code indicates the patient's status as of the "through" date of the billing period (FL 6). |
| FL 4 | Type of bill (three-character alphanumeric identifier) | FLs 18–28 | Condition codes |
| FL 5 | Federal Tax Identification Number | FL 29 | Accident state |
| FL 6 | Statement covers period (from–through). The beginning and ending dates of the period included on the bill are shown in numeric fields (MM-DD-YY). | FL 30 | Not required |
| FL 7 | Not required | FLs 31–34 | Occurrence codes and dates |
| FL 8a–b | Patient's name (surname first, first name and middle initial, if any). Enter the patient's SSN in field "a." Enter the patient's name in field "b." | FLs 31–34 | Occurrence codes and dates |
| FL 9a–e | Patient's address including ZIP code. This must be a physical address. Post office boxes are not acceptable. | FLs 35–36 | Occurrence span code and dates |
| FL 10 | Patient's birth date (MM-DD-YYYY). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled. | FL 37 | Not required |
| FL 11 | Patient's sex. This item is used in conjunction with FLs 66–69 (diagnoses) and FL 74 a – e (surgical procedures) to identify inconsistencies. | FL 38 | Responsible party name and address |
| FL 12 | Admission date | FLs 39–41 | Value codes and amounts |
| FL 13 | Admission hour | FL 42 | Revenue code |
| | | FL 43 | Revenue description – A narrative description or standard abbreviation for each revenue code in FL 42. Descriptions or abbreviations correspond to the revenue codes. |
| | | FL 44 | HCPCS/rates. When coding HCPCS, enter the HCPCS code describing the procedure. May be required for correct reimbursement. |
| | | FL 45 | Service date. If submitting claims for outpatient services, report a separate date for each day of service. |
| | | FL 46 | Service units. The entries in this column quantify services by revenue category (for example, number of days, a particular type of accommodation, pints of blood). Up to seven digits may be entered. |



FL 47	Total charges	FL 62A–C	Insurance Group Number
FL 48	Non-covered charges. The total non-covered charges pertaining to the related revenue code in FL 42 is entered here.	FL 63A–C	Treatment authorization code. Contractor specific or HHA PPS OASIS code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient pre-admission or pre-procedure, the authorization number is required for all approved admissions or services.
FL 49	Not required	FL 64A–C	Document control number (DCN). Original DCN number of the claim to be adjusted.
FL 50A–C	Payer identification. Enter the primary payer on line A.	FL 65A–C	Employer name. Name of the employer that provides health care coverage for the individual identified on FL 58.
FL 51A–C	Health Plan Identification Number	FL 66	Diagnosis and procedure code qualifier (ICD Version Indicator)
FL 52A–C	Release of information. A “Y” code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An “R” code indicates the release is limited or restricted. An “N” code indicates no release on file.	FL 67	Principal diagnosis code. Centers for Medicare and Medicaid Services (CMS) only accepts ICD-9-CM diagnostic and procedural codes which use definitions contained in Department of Health and Human Services (DHHS) 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 five digits where applicable.
FL 53A–C	Assignment of benefits certification indicator	FL 67A–Q	Other diagnosis codes
FL 54A–C	Prior payments. For all services other than inpatient hospital and skilled nursing facility services, the sum of any amount(s) collected by the provider from the patient toward deductibles and/or co-insurance are entered on the patient (last) line of this column.	FL 68	Not required
FL 55A–C	Not required	FL 69	Admitting diagnosis. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient’s hospital admission.
FL 56	National Provider Identifier (NPI).	FL 70a–c	Patient’s reason for visit
FL 57A–C	Other Provider Identifier Number	FL 71	Prospective payment system code
FL 58A–C	Insured’s name	FL 72a–c	External cause of injury code
FL 59A–C	Patient’s relationship to insured	FL 73	Not required
FL 60A–C	Certificate/Social Security number/health insurance claim/identification number		
FL 61A–C	Group name. Indicate the name of the insurance group or plan.		



- FL 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.
- FL 74a–e** Other procedure codes and dates. The full ICD-9-CM, Volume 3, Procedure Codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL 74). The date of each procedure is shown in the date portion of Item 74, as applicable (MM-DD-YY).
- FL 75** Not required
- FL 76** Attending/referring physician ID
- FL 77** Operating physician name and identifiers
- FL 78–79** Other physician ID
- FL 80** Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Authorized signature of non-network providers.
- FL 81a–d** Code field

Condition Codes

- | | |
|--|--|
| 02 Condition is employment related | 48 Psychiatric residential treatment centers for children and adolescents |
| 03 Patient covered by insurance not reflected here | 55 Skilled nursing facility bed not available |
| 06 End-stage renal disease patient in first 30 months of entitlement covered by employer group health insurance | 56 Medical appropriateness |
| 08 Beneficiary would not provide information concerning other insurance coverage | 60 Day outlier |
| 18 Maiden name retained | 61 Cost outlier |
| 19 Child retains mother's name | 67 Beneficiary elects not to use lifetime reserve days |
| 31 Patient is student (full-time – day) | A0 TRICARE External Partnership Program |
| 33 Patient is student (full-time – night) | A2 Physically Handicapped Children's Program |
| 34 Patient is student (part-time) | C1 Approved as billed |
| 36 General care patient in a special unit | C2 Automatic approval as billed based on focused review |
| 38 Semi-private room not available | C3 Partial approval |
| 39 Private room medically necessary | C4 Admission/services denied |
| 40 Same-day transfer | C5 Post-payment review applicable |
| 41 Partial hospitalization | C6 Admission prior authorization |
| 46 Non-availability statement on file | C7 Extended authorization |
| | G0 Distinct medical visit (OPPS) |



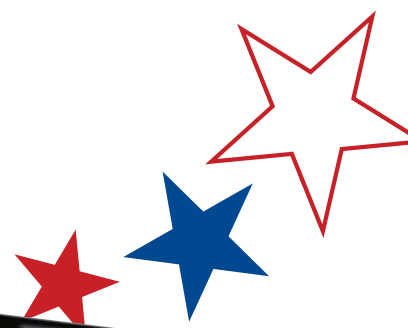
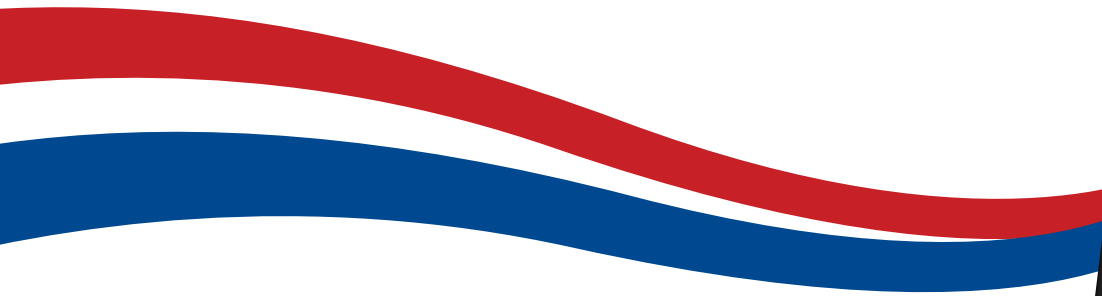
Occurrence Span Codes

- 01** Auto accident
- 02** No fault insurance involved – including auto accident/other
- 03** Accident/tort liability
- 04** Accident/employment related
- 05** Accident/No medical or liability coverage
- 06** Crime victim
- 21** Date UR notice received
- 22** Date active care ended
- 24** Date insurance denied
- 25** Date benefits terminated by primary payer
- 26** Date skilled nursing facility bed became available
- 27** Date of hospice certification or recertification
- 28** Date comprehensive outpatient rehabilitation plan established or last reviewed
- 29** Date outpatient physical therapy plan established or last reviewed
- 30** Date outpatient speech pathology plan established or last reviewed
- 31** Date beneficiary notified of intent to bill (accommodations)
- 32** Date beneficiary notified of intent to bill (procedures or treatments)
- 33** First day of the Medicare coordination period for end-stage renal disease beneficiaries covered by Employer Group Health Plan

Value Codes and Amounts

- 01** Most common semi-private rate
- 02** Hospital has no semi-private rooms
- 05** Professional component included in charges and also billed separate to carrier
- 30** Pre-admission testing
- 31** Patient liability amount
- 37** Pints of blood furnished
- 46** Number of grace days

www.hnfs.com



HH0213x009x0213

