# 2013 Provider Handbook

TRICARE®

South Region

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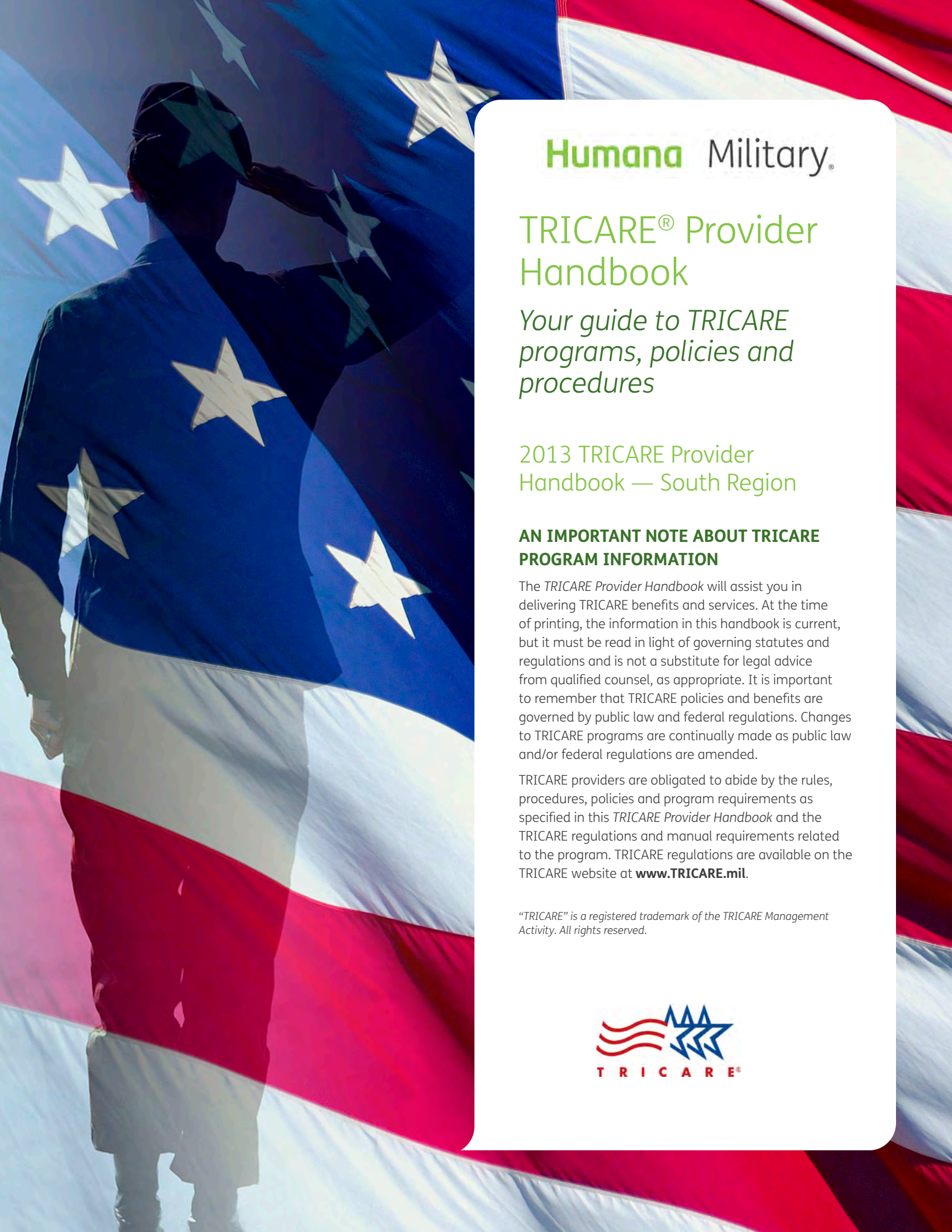

Humana Military

# TRICARE® Provider Handbook

## *Your guide to TRICARE programs, policies and procedures*

## 2013 TRICARE Provider Handbook — South Region

### AN IMPORTANT NOTE ABOUT TRICARE PROGRAM INFORMATION

The *TRICARE Provider Handbook* will assist you in delivering TRICARE benefits and services. At the time of printing, the information in this handbook is current, but it must be read in light of governing statutes and regulations and is not a substitute for legal advice from qualified counsel, as appropriate. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended.

TRICARE providers are obligated to abide by the rules, procedures, policies and program requirements as specified in this *TRICARE Provider Handbook* and the TRICARE regulations and manual requirements related to the program. TRICARE regulations are available on the TRICARE website at **www.TRICARE.mil**.



TRICARE®

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## Using this TRICARE Provider Handbook

The *TRICARE Provider Handbook* provides you and your staff with basic, important information about TRICARE, while emphasizing key operational aspects of the program and program options. This handbook will assist you in coordinating care for TRICARE beneficiaries. It contains information about specific TRICARE programs, policies and procedures. Annual updates to the *TRICARE Provider Handbook* serve to keep you informed of changes to the TRICARE program.

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# Table of Contents

# Welcome to TRICARE and the South Region

## What Is TRICARE?

TRICARE is the Department of Defense's (DoD's) worldwide health care program available to eligible beneficiaries in any of the seven uniformed services — the U.S. Army, the U.S. Navy, the U.S. Air Force, the U.S. Marine Corps, the U.S. Coast Guard, the Commissioned Corps of the U.S. Public Health Service and the Commissioned Corps of the National Oceanic and Atmospheric Administration.

TRICARE-eligible beneficiaries may include 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.

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 managed jointly by the TRICARE Management Activity (TMA) and TRICARE Regional Offices. TMA has contracted 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

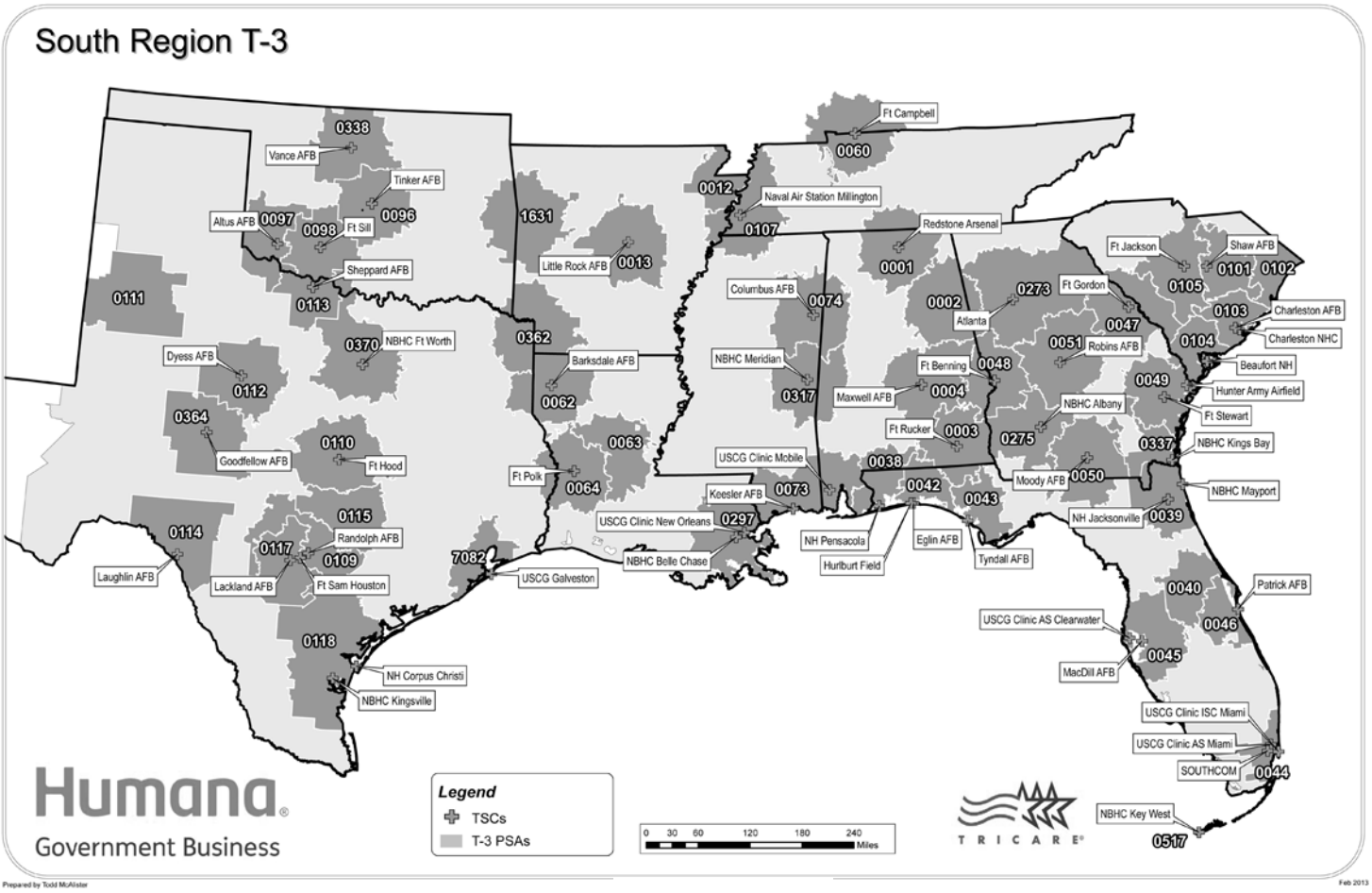
Humana Military, a division of Humana Government Business, Inc., administers the TRICARE program in the South Region, which includes Alabama, Arkansas, Florida, Georgia, Kentucky (the Fort Campbell area only), Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee and Texas (excluding the El Paso area).

Humana Military is committed to preserving the integrity, flexibility and durability of the Military Health System (MHS) by offering beneficiaries access to the finest health care services available, thereby contributing to the continued superiority of U.S. combat readiness.

Figure 1.1 displays a map of the three TRICARE regions in the United States. Figure 1.2 on the following page shows the TRICARE South Region.

TRICARE Regions Figure 1.1

TRICARE South Region Figure 1.2




# Humana Military Network Subcontractors and Vendors

Humana Military develops and maintains TRICARE contract administration and utilizes various partnerships for certain services:

- ValueOptions®, Inc. is Humana Military's behavioral health care contractor in the TRICARE South Region. ValueOptions is the largest privately held behavioral health managed care company in the nation.
- PGBA, LLC is Humana Military's claims processing contractor in the TRICARE South Region. PGBA is one of the largest subsidiaries of BlueCross BlueShield of South Carolina.

# Provider Resources

Many national and regional resources are available if you or your staff has questions or concerns about TRICARE programs, policies or procedures. These resources can also help you coordinate care for your TRICARE patients.

## Humana-Military.com

Humana Military's website hosts a full array of interactive services designed to save providers time and money. The provider portal features pages customized for providers as well as a section for Primary Care Managers (PCMs).

Visit **Humana-Military.com** to:

- Learn about TRICARE programs and coverage.
- Access forms and tutorials.
- Learn about provider education opportunities.
- Get billing guidelines.
- Locate TRICARE providers using the Find a Provider tool.
- Access Self-Service for Providers, Humana Military's secure self-service portal.

## Interactive Voice Response (IVR)

Providers that do not have Internet access can take advantage of Humana Military's Interactive Voice Response (IVR) system through our toll-free service line, **1-800-444-5445**. This line is available 24 hours a day, seven days a week.

The IVR system responds to your natural speech patterns or touch-tone responses. It is an easy way to get answers to routine questions, such as verifying beneficiary eligibility, checking the status of claims and reviewing the status of referral and prior authorization requests.

You can use Humana Military's IVR to:

- Look up procedure codes.
- Check the status of claims.

- Determine eligibility and covered benefits.
- Check the status of referrals, authorizations and behavioral health referrals.

### TRICARE Policy Resources and Manuals: http://manuals.tricare.osd.mil

TMA provides Humana Military with guidance — as issued by the DoD — for administering TRICARE-related laws. The DoD issues this direction through modifications to the Code of Federal Regulations (CFR).

The *TRICARE Operations Manual*, *TRICARE Reimbursement Manual* and *TRICARE Policy Manual* are continually 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 Chapter 55 of Title 10 of the United States Code, which contains all statutes regarding the armed forces. Unless specified otherwise, federal laws generally supersede state laws.

This *TRICARE Provider Handbook* provides an overview of the TRICARE program regulations and requirements contained in the *TRICARE Policy Manual*, *TRICARE Operations Manual* and *TRICARE Reimbursement Manual*. To view the complete manuals and other TRICARE policies, visit **http://manuals.tricare.osd.mil**.

Refer to these TRICARE manuals as well as to the *TRICARE Provider News* publication and **Humana-Military.com** for current information about policy changes, timelines and implementation guidance.

## Self-Service for Providers, Humana-Military.com's Secure Portal

Self-Service for Providers features numerous online applications designed to improve cash flow and increase office productivity by reducing the amount of time providers and their office staff members spend communicating with Humana Military via telephone and fax.

With Self-Service for Providers, providers can quickly and easily:

- Verify patient eligibility: Check up to five patients at the same time.
- Create referrals and authorizations: Enter new requests in five easy steps.
- Review referrals and authorizations: Check status or update requests.
- Check claim status: Review TRICARE claims in detail.
- Manage profile: Update information, and check quality and affordability data.
- Access pharmacy data by patient: Check history before writing new prescriptions.
- Look up codes: Check if a service requires a referral or authorization.

To access Self-Service for Providers, providers must register to obtain a user ID and password for the Humana Military website. To register, go to **Humana-Military.com**, click **Provider** and click the **Register Today** button in the blue Self-Service box, and follow the prompts of the Registration Wizard.

When registering for Self-Service for Providers, providers have four different options for gaining access:

- **Site administrator express code:** Providers may use an express code from a local site administrator responsible for the provider ID they want to access.
- **Existing referral information:** Providers may enter the Auth/Order number and key code shown on a received *Humana Military—TRICARE Referral/Authorization* fax. The provider ID that they are requesting access for must be associated with the Auth/Order number entered.
- **Onsite Humana Military provider representative validation:** The provider representative must enter several key codes to grant a provider immediate access to Self-Service for Providers.
- **Manual approval:** If the previous options are unavailable, providers may submit an approval request to a local site administrator (usually a person who works for the provider) for the provider ID they want to access. Local site administrators are responsible for activating or rejecting all requests to access provider IDs. Humana Military does not control how quickly local site administrators respond to access requests. If a local site administrator does not exist, a Humana Military provider representative will review the request and confirm or deny the right to obtain access. This process usually takes approximately three business days.

## Other Provider Resources

Figure 1.3 on the following page provides a list of other provider resources, including claims processing, referrals, prior authorizations, provider relations and more.

| Resource | Description | Contact Information |
|---|---|---|
| **Allowable charges** | View and download TRICARE allowable charge rates (also known as CMAC). | www.TRICARE.mil/CMAC |
| **Behavioral Health Care: ValueOptions, Inc.** | Contact ValueOptions for information about behavioral health benefits, patient eligibility verification, authorizations and claims. | Humana-Military.com<br>1-800-700-8646 |
| **Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)** | Administered by the Department of Veterans Affairs, CHAMPVA is separate program from TRICARE program. | www.va.gov/hac/forproviders<br>1-800-733-8387<br>VA Health Administration Center<br>CHAMPVA<br>P.O. Box 469064<br>Denver, CO 80246-9064 |
| **Claims: PGBA, LLC** | Contact the South Region claims processor for assistance with claims-related issues. | www.myTRICARE.com<br>1-800-403-3950 |
| **PGBA Electronic Data Interchange (EDI) Help Desk** | Contact PGBA's EDI Help Desk for assistance with issues related to TRICARE electronic claims submissions. | 1-800-325-5920, option 2 |
| **Fraud and abuse** | Anonymously report suspected fraud or abuse to Humana Military. | Humana-Military.com<br>1-800-333-1620 |
| **Military Medical Support Office (MMSO)** | Contact the MMSO for assistance regarding health care for active duty Army, Navy, Air Force, Marine Corps, Coast Guard and certain TRICARE-eligible National Guard and Reserve members. | www.TRICARE.mil/MMSO<br>1-888-MHS-MMSO (1-888-647-6676)<br>Military Medical Support Office<br>P.O. Box 886999<br>Great Lakes, IL 60088-6999 |
| **Provider data management: PGBA** | Contact PGBA for assistance with provider certification and non-network provider demographic updates. | 1-800-403-3950<br>Fax: 1-803-462-3986<br>www.myTRICARE.com |
| **Pharmacy services: Express Scripts, Inc.** | Contact the TRICARE Pharmacy Program contractor for assistance with pharmacy benefits, claims, prior authorization, and other services and requirements. | www.express-scripts.com/TRICARE<br>1-877-363-1303<br>Fax: 1-877-895-1900<br>Express Scripts, Inc.<br>P.O. Box 52150<br>Phoenix, AZ 85072 |
| **Referrals and prior authorizations** | Check the status of referral and prior authorization requests. | Humana-Military.com<br>1-800-444-5445 |
| **TRICARE For Life (TFL): Wisconsin Physicians Service/TRICARE Dual Eligible Fiscal Intermediary Contract (WPS/TDEFIC)** | Contact the TFL administrator for assistance with TFL benefits, claims and requirements. | www.TRICARE4u.com<br>1-866-773-0404<br>1-866-773-0405 (TDD)<br>WPS/TDEFIC<br>P.O. Box 7889<br>Madison, WI 53707-7889<br>(general correspondence only, no claims) |
| **US Public Health Service (USPHS)** | Obtain assistance regarding health care for USPHS personnel. | 1-800-368-2777, option 2 |
| **Warrior Navigation and Assistance Program (WNAP)** | Get information and assistance to help combat Veterans — ADSMs, National Guard and Reserve members, and medically retired service members — navigate military health care systems, U.S. Department of Veterans Affairs health systems, community resources and the civilian health care sector. | Humana-Military.com/WNAP<br>1-888-4GO-WNAP (1-888-446-9627) |

# Important Provider Information



Contracted TRICARE providers must abide by the rules, procedures, policies and program requirements specified in this TRICARE Provider Handbook and the TRICARE regulations and requirements related to the TRICARE program. Please read this handbook in light of governing statutes and regulations; it is not a substitute for legal advice from qualified counsel, as appropriate. For more information, visit **Humana-Military.com**.

## Healthy People 2020

In December 2010, the Department of Health and Human Services launched Healthy People 2020, the latest incarnation of a 30-year initiative to increase the health and wellness of the U.S. population. Healthy People provides 10-year national objectives for improving the health of all Americans.

Healthy People 2020 organizes its high-priority health issues into 12 topic areas consisting of 26 Leading Health Indicators (LHIs). LHIs focus on significant threats to the public's health, offering statistics, targets and clinical recommendations to reach the targets.

These 12 topic areas are Access to Health Services; Behavioral Health; Clinical Preventive Services; Environmental Quality; Injury and Violence; Maternal, Infant and Child Health; Nutrition, Physical Activity and Obesity; Oral Health; Reproductive and Sexual Health; Social Determinants; Substance Abuse; and Tobacco.

Please consider Healthy People initiatives and their LHIs for overall health, wellness and prevention for our beneficiaries by implementing prevention education and ensuring wellness care programs. The Healthy People 2020 program seeks interested providers to participate and receive materials.

For more information on Healthy People 2020, search for **Healthy People 2010-2020** at **Humana-Military.com**.

## MyActiveHealth and Care Considerations

Humana Military has partnered with ActiveHealth Management® to help TRICARE beneficiaries improve their health and better manage chronic health conditions. ActiveHealth Management analyzes medical claims, lab results, pharmacy and self-reported data to identify potential gaps in care.

We share this information by sending Care Considerations to TRICARE beneficiaries and their providers. Providers can use these Care Considerations to begin a dialogue with patients to encourage them to take a more active role in maintaining their health as well as seek needed preventive care services.

We also ask providers to provide feedback regarding patients' Care Considerations. Submitting feedback helps incorporate important patient information that claims data can't supply, such as drug intolerance or allergies. Such information can help increase the accuracy of future recommendations for the patient and help them improve their health and wellness overall.

Providers can easily provide feedback on Care Considerations via the Web. Go to **Humana-Military.com**, select **Provider** and click **Submit Feedback** under Care Considerations on the right-hand side. Then enter the Tracking Number and the Key Pass Code from the Care Consideration, and click the **Enter** button. Providers will then be able to enter feedback.

To learn more about MyActiveHealth and Care Considerations, search for **Care Considerations** at **Humana-Military.com**.

## HEDIS® Performance Measures

The TRICARE Management Activity (TMA) has challenged Humana Military to collaborate with its network providers to improve the HEDIS scores of TRICARE beneficiaries. The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

NCQA designed HEDIS to allow consumers to compare their health plan's performance to other plans and to national or regional benchmarks. Although not originally intended for trending, HEDIS results are increasingly used to track year-to-year performance as well.

The HEDIS performance measures address a broad range of important health issues, including:

- Comprehensive diabetes care
- Breast cancer screening
- Cervical cancer screening
- Colorectal screening
- Childhood and adolescent immunization status
- Use of appropriate medications for people with asthma

Improving HEDIS scores is another element of Humana Military's ongoing efforts to help TRICARE beneficiaries improve their health and better manage chronic health conditions. This goal also supports the Population Health segment of the TMA's Quadruple Aim. This segment seeks to reduce generators of ill health by encouraging healthy behaviors and decreasing likelihood of illness through focused prevention and increased resilience.

For more information on HEDIS, search for **HEDIS** at **Humana-Military.com**.

# Pharmacy Data Transaction System

The Pharmacy Data Transaction System (PDTS) is a feature available from Humana Military's Self-Services for Providers secure portal. PDTS is a centralized data repository that records information about TRICARE beneficiaries' prescriptions.

PDTS allows providers to access complete patient medication histories, helping providers gain a better understanding of a patient's medication history, find out refill schedule and supply amounts, prevent possible duplications or negative interactions, and help ensure patient safety. This is particularly useful when patients are seeing more than one doctor.

Regardless of where a beneficiary fills a prescription, the prescription information is available to authorized PDTS providers, including TRICARE Pharmacy Home Delivery, MTF pharmacies, MTF providers and TRICARE retail network pharmacies.

To access PDTS, log in to the secure Self-Service for Providers at **Humana-Military.com**.

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

The HIPAA Privacy Rule generally requires individual health care providers, institutional providers such as Military Treatment Facilities (MTFs), their workforce members and their contractors to use and disclose Protected Health Information (PHI) only as permitted or required by the HIPAA Privacy Rule. PHI is individually identifiable health information, which includes demographic and payment information created and obtained by providers who deliver health services to patients.

The HIPAA Privacy Rule permits providers to use and disclose PHI without a patient's written authorization for purposes of treatment, payment and health care operations. The HIPAA Privacy Rule also permits uses and disclosures of PHI without a patient's authorization in various situations not involving treatment, payment and health care operations.

In the Military Health System (MHS), one of the most important exceptions to the authorization requirement is the military command exception. This permits limited disclosures of PHI about Active Duty Service Members (ADSMs) to their military commanders to determine fitness for duty or certain other purposes. Similarly, PHI of service members separating from the armed forces may be disclosed to the U.S. Department of Veterans Affairs (VA).

For more detailed guidance and information on the HIPAA Privacy Rule, search for **Privacy** at **Humana-Military.com**.

Providers must establish administrative, physical and technical safeguards. Actual or possible unauthorized use or disclosure of PHI (i.e., a breach) may require notifying affected individuals and reporting to TMA and other government entities. For more information on responding to privacy breaches, visit **www.TRICARE.mil/TMA/privacy/breach.aspx**.

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

The *Military Health System Notice of Privacy Practices* form informs beneficiaries about their rights regarding PHI and explains how PHI may be used or disclosed, who can access PHI and how PHI is protected. The notice is published in 11 languages. Braille and audio versions are also available. Visit **www.TRICARE.mil/TMA/privacy/HIPAA-NOPP.aspx** to download copies of the *Military Health System Notice of Privacy Practices*.

Privacy officers are available for every MTF. They serve as beneficiary advocates for privacy issues and respond to beneficiary inquiries about PHI and privacy rights.

For more information about privacy practices and other HIPAA requirements, visit **www.TRICARE.mil/HIPAA**. Beneficiaries and providers may also email inquiries to **privacymail@tma.osd.mil**.

## Release of Medical Records and Other PHI

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

Contraindications may include circumstances involving unemancipated minors and applicable state laws, and abuse, neglect or endangerment situations. In addition, special care should be taken when PHI includes unusually sensitive medical conditions, such as abortion, pregnancy, AIDS, sexually transmitted diseases, alcoholism or other substance abuse, and behavioral health conditions.

Humana Military representatives must comply with the Privacy Act of 1974 and HIPAA Privacy Rules when TRICARE beneficiaries call regarding claims and other patient benefit information. If a person requests information on behalf of a TRICARE beneficiary, Humana Military may not disclose information until the proper legal paperwork is received.

For additional questions about the HIPAA Privacy Rule and TRICARE, visit **www.TRICARE.mil/TMAprivacy** or **www.HHS.gov/ocr/privacy**.

# What Is a TRICARE Provider?

TRICARE defines a provider as a person, business or institution that provides health care. Providers must be authorized under TRICARE regulations in order for TRICARE beneficiaries to cost-share claimed services. Humana Military contracts with network providers in the South Region to deliver health care to TRICARE beneficiaries.

## Military Treatment Facilities

An MTF is a military hospital or clinic usually located on or near a military base. The civilian TRICARE provider network supplements MTF resources and may work closely with MTFs to ensure patients get the care they need. To locate an MTF, visit **www.TRICARE.mil/MTF**.

## TRICARE-Certified Providers vs. TRICARE Network Providers

A **TRICARE-certified provider** is a person, business or organization that meets the licensing and certification requirements of TRICARE regulations and practices for that area of health care. Providers must be TRICARE-certified through PGBA, Humana Military's claims processing partner, in order to file claims and receive payment for TRICARE services.

TRICARE-certified providers may or may not agree to "accept assignment," which means accepting the TRICARE allowable charge as payment in full for services. Providers that do not agree are considered authorized nonparticipating providers, also known as TRICARE-certified, non-network providers. These providers may elect to accept assignment on a claim-by-claim basis.

A **TRICARE network provider** is a TRICARE-certified provider who has a written agreement with Humana Military. TRICARE network providers agree to accept the TRICARE allowable charge less any agreed-on discount as payment in full for the services provided and to submit claims on behalf of beneficiaries.

Figure 2.1 provides an overview of TRICARE provider types.

## Primary Care Managers (PCMs)

PCMs coordinate all care for their patients and provide nonemergency care whenever possible. PCMs also maintain patient medical records and refer patients for specialty care that they cannot provide.

When required, PCMs work with Humana Military to obtain referrals and prior authorizations. See the *Health Care Management and Administration* section for more information about referral and authorization requirements.

PCMs can be MTF or civilian TRICARE network providers. The following provider specialties may serve as TRICARE PCMs:

- Family practitioners
- General practitioners
- Internal medicine physicians
- Nurse practitioners
- Pediatricians
- Obstetricians and gynecologists (Gender restrictions apply.)

See *PCM's Role* later in this section for more information about PCM roles and responsibilities.



## TRICARE Provider Types — Figure 2.1

**TRICARE-Authorized Providers**

- TRICARE-authorized providers meet state licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (nurse practitioners, physician assistants and physical therapists), laboratory and radiology providers, and pharmacies. 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**.
- TRICARE covers services delivered by qualified TRICARE-authorized behavioral health care providers practicing within the scope of their licenses to diagnose and/or treat covered behavioral health components of an otherwise diagnosed medical or psychological condition.

| **Network Providers[1]** | **Non-Network Providers[2]** | |
|---|---|---|
| Regional contractors have established networks, even in areas far from MTFs.<br><br>TRICARE network providers:<br><br>• Have agreements with Humana Military to provide care. For behavioral health services, agreements are with ValueOptions.<br><br>• Agree to file claims and handle other paperwork for TRICARE beneficiaries. | Non-network providers do not have agreements with Humana Military or ValueOptions and are therefore considered non-network.<br><br>There are two types of non-network providers: **participating** and **nonparticipating**. | |
| | **Participating Providers** | **Nonparticipating Providers** |
| | • May choose to participate on a claim-by-claim basis.<br><br>• Agree to accept payment directly from TRICARE and accept the TRICARE allowable charge as payment in full for their services. | • Do not agree to accept the TRICARE allowable charge or file claims for TRICARE beneficiaries.<br><br>• Have the legal right to charge beneficiaries up to 15 percent above the TRICARE allowable charge for services. |

*1. Network providers must have malpractice insurance.*
*2. To inquire about becoming a network provider, search for **Join the Network** at **Humana-Military.com**. (Information about behavioral health network participation is available from the same Web page.)*

## Corporate Services Provider (CSP) Class

The CSP 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 provider types in this category may include:

- Cardiac catheterization clinics
- Comprehensive outpatient rehabilitation facilities
- Diabetic outpatient self-management education programs (American Diabetes Association® accreditation required)
- Freestanding bone-marrow transplant centers
- Freestanding kidney dialysis centers
- Freestanding Magnetic Resonance Imaging (MRI) centers
- Freestanding sleep-disorder diagnostic centers
- Home health agencies (pediatric or maternity management required)
- Home infusion (Accreditation Commission for Health Care accreditation required)
- Independent physiological laboratories
- Radiation therapy programs

Non-network CSPs must apply to become TRICARE-authorized. Qualified non-network providers can download the *Application for TRICARE-Provider Status/Corporate Services Provider* at **www.myTRICARE.com**. Only after receiving the CSP's application can Humana Military then network the CSP.

CSPs who deliver home health care are exempt from prospective payment system billing rules. For more information about CSP coverage and reimbursement, refer to the *TRICARE Policy Manual*, Chapter 11, Section 12.1 at **http://manuals.tricare.osd.mil**.

# Provider Certification and Credentialing

## TRICARE Certification

TRICARE only reimburses appropriate covered services for eligible beneficiaries provided by 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. Non-network providers may also choose to "accept assignment" (i.e., 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. Nonparticipating non-network providers do not have to accept the TRICARE allowable charge or file claims for beneficiaries.

Providers may see TRICARE patients and file claims with TRICARE to initiate the certification process. All providers must submit certification forms to PGBA to become a TRICARE-certified provider. To download the forms, visit **www.myTRICARE.com** and search for **Provider Forms South**.

In addition, freestanding Partial Hospitalization Programs (PHPs), Residential Treatment Centers (RTCs), and Substance Use Disorder Rehabilitation Facilities (SUDRFs) must first be certified by KePRO, the TRICARE Quality Monitoring Contractor (TQMC). Call KePRO at **1-877-841-6413** to speak with TRICARE certification representatives and request information.

Once KePRO certifies the facility, the provider must complete the ValueOptions contracting process. Call ValueOptions at **1-800-700-8646** for more information.

**Note:** Separate TRICARE certification of hospital-based PHPs is not required. When a hospital is a TRICARE-authorized provider, the hospital's PHP is also considered a TRICARE-authorized provider. However, freestanding PHPs must be certified and enter into a participation agreement with TRICARE and obtain the required authorization prior to admitting patients. Freestanding PHPs interested in becoming TRICARE-authorized must contact KePRO.

## TRICARE Credentialing

To join the TRICARE network, a TRICARE-authorized provider must complete the credentialing process and sign a contract with Humana Military (or ValueOptions for behavioral health). Humana Military's credentialing process requires primary-source/acceptable source verification of the provider's education/training, board certification, license, professional and criminal background, malpractice history and other pertinent data.

To meet the minimum credentialing criteria established by Humana Military, individuals must:

- Have graduated from a school appropriate to their profession and completed postgraduate training appropriate to their practicing specialty.
- Have a current, valid, unrestricted and unprobated professional state license* in the state(s) they practice within.
- Have a current, valid, unrestricted and unprobated Drug Enforcement Agency (DEA) registration, if applicable to their practicing specialty.
- Have a current, valid, unrestricted and unprobated State Controlled Dangerous Substance registration, if applicable to their practicing specialty and the state they practice within.
- Have current professional liability insurance or meet the state/local guidelines.
- Be able to participate in federal health care programs.
- Not have been convicted of a felony related to controlled substances, health care fraud, or a child or patient abuse.
- Not have any physical or behavioral health condition that

cannot be accommodated without undue hardship or without reasonable accommodation.

- Not have untreated chemical/substance dependency.
- Not have any unexplained gaps of six months or more in their work history during the past five years.

*See the *TRICARE Policy Manual* 6010.54-M, AUGUST 1, 2002, Chapter 11, Section 3.2, State Licensure and Certification Policy.

Providers requiring credentialing include:

- Medical Doctors (MDs) (if not hospital-based, active duty, urgent care or VA)
- Doctors of Osteopathic Medicine (DOs) (if not hospital-based, active duty, urgent care or VA)
- Doctors of Dental Medicine (DMDs) (must practice oral and maxillofacial surgery)
- Doctors of Dental Surgery (DDSs) (must practice oral and maxillofacial surgery)
- Doctors of Podiatric Medicine (DPMs)
- Doctors of Optometry (ODs)
- Nurse Practitioners (NPs)

Credentialing is also required for acute inpatient facilities, freestanding surgical centers, home health agencies and Skilled Nursing Facilities (SNFs).

To meet the minimum credentialing criteria established by Humana Military, facilities must:

- Have a current signature and date on the application.
- Have a current, valid, unrestricted and unprobated state license.
- Have current acceptable liability insurance.
- Be able to participate in federal health care programs, including Medicare, Medicaid and all other plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan) as reported by the Office of the Inspector General (OIG) or the General Services Administration (GSA).
- Have acceptable accreditation status appropriate to the facility.

The provider must wait to receive final notification of contract execution and credentialing approval from Humana Military before providing care to TRICARE beneficiaries as a network provider. Humana Military monitors each network provider's quality of care and adherence to DoD, TRICARE and Humana Military policies. Network providers must be recredentialed **at least** every three years.

For more information, search for **Join the Network** at **Humana-Military.com**.

Behavioral health care providers — including freestanding PHPs, RTCs and SUDRFs — must also be credentialed by ValueOptions. For credentialing criteria for behavioral health care providers, see the Behavioral Health Care Services section.

For more information or to apply to join the TRICARE network, call ValueOptions at **1-800-700-8646** or send an email to **provhelptricare@jax.valueoptions.com**.

# Provider Responsibilities

Network providers have contracts with Humana Military and must comply with all TRICARE program rules and regulations and Humana Military policies. **This handbook is not all-inclusive** and provides an overview of TRICARE program rules and regulations and Humana Military policies and procedures. Visit **Humana-Military.com** for more information about provider responsibilities.

## Nondiscrimination Policy

All TRICARE-authorized providers agree not to discriminate against any TRICARE beneficiary on the basis of his or her race, color, national origin or any other basis recognized in applicable laws or regulations. To access the full TRICARE policy, refer to the *TRICARE Operations Manual*, Chapter 1, Section 5 at **http://manuals.tricare.osd.mil**.

## Office and Appointment Access Standards

TRICARE access standards ensure that 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 nonemergency care:

- Preventive care appointment: Four weeks (28 days)
- Routine care appointment: One week (seven days)
- Specialty care appointment: Four weeks (28 days)
- Urgent care or acute illness appointment: One day (24 hours)

Office wait times for nonemergency care appointments shall not exceed 30 minutes except when the provider's normal appointment schedule is interrupted due to an emergency. Providers that are running behind schedule should 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.

## Missed Appointments

TRICARE regulations do not prohibit providers from charging missed appointment fees. TRICARE providers are within their rights to enforce practice standards, as stipulated in clinic

policies and procedures that require beneficiaries to sign agreements to accept financial responsibility for missed appointments. TRICARE does not reimburse beneficiaries for missed appointment fees.

## PCM's Role

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

Here is an overview of the PCM's roles and responsibilities:

- Primary care services are typically, although not exclusively, provided by internal medicine physicians, family practitioners, pediatricians, general practitioners and, in some cases, nurse practitioners.
- When a provider signs a contractual agreement to become a PCM, he or she must follow TRICARE procedures and requirements for obtaining specialty referrals and prior authorizations for nonemergency inpatient and certain outpatient services.
- In the event the assigned PCM cannot provide the full range of primary care functions necessary, the PCM must ensure access to the necessary health care services, as well as any specialty requirements.
- PCMs are required to provide access to care 24 hours a day, seven days a week, including after-hours and urgent care services, or arrange for on-call coverage by another provider.

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

  - Routine care: The PCM or on-call provider instructs the TRICARE Prime beneficiary to contact the PCM's office on the next business day for an appointment.
  - Urgent care: The PCM or on-call provider coordinates timely care for the TRICARE Prime beneficiary.
  - The on-call physician should contact the PCM within 24 hours of an inpatient admission to ensure continuity of care.
- PCMs referring patients for specialty care may need to coordinate the referral with Humana Military.
- ADSMs **must** have referrals for all care outside of MTFs (except for emergencies or as provided in TRICARE Prime Remote [TPR] regulations, if applicable), including all behavioral health care services. If the ADSM has an assigned civilian PCM under TRICARE Prime or TPR, all specialty referral and authorization guidelines must be followed.

## Specialty Care Responsibilities

Specialty care may require prior authorization from Humana Military as well as referrals from PCMs (for TRICARE Prime enrollees) and/or Humana Military.

TRICARE Prime beneficiaries who live within a 60-minute drive time of an MTF may be required to first seek specialty care, ancillary services and physical therapy at the MTF based on the MTF's Right Of First Refusal (ROFR). See *MTF Right of First Refusal* in the *Health Care Management and Administration* section.

PCMs and/or specialty care providers must coordinate with Humana Military to obtain referrals and prior authorizations. A network provider who submits a claim for an unauthorized service is subject to a penalty of up to 50 percent of the TRICARE allowable charge.

Network behavioral health care providers have agreements with ValueOptions to follow rules and procedures regarding behavioral health care. Although a PCM referral is not required for behavioral health care services (except for ADSMs), prior authorization may be required from ValueOptions.

Care rendered without prior authorization will be reviewed retrospectively and may result in a penalty of up to 50 percent. The cost of this penalty will be borne by the provider, and the beneficiary is held harmless.

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

- TRICARE Prime:
  - ADSMs: PCM and/or Humana Military/ValueOptions referrals are required for all civilian specialty care. In addition, prior authorization from Humana Military/ValueOptions is required for certain services.
  - Active Duty Family Members (ADFMs): PCMs should refer patients to MTFs or network providers whenever possible. ADFMs must obtain PCM and/or Humana Military referrals for any care they receive from providers other than their PCMs, except for preventive care services from network providers, behavioral health care visits for medically necessary treatment for covered conditions by network providers who are authorized under TRICARE regulations to see patients independently or when using the Point-Of-Service (POS) option. In addition, prior authorization from Humana Military/ValueOptions is required for certain services.
- TRICARE Standard: Beneficiaries may self-refer to TRICARE-authorized specialty care providers. However, prior authorization from Humana Military/ValueOptions is required for certain services.
- TRICARE For Life: Beneficiaries may self-refer to Medicare-certified providers. However, prior authorization from Humana Military/ValueOptions is required for certain services.

Providers should request referrals and prior authorizations via the secure Self-Service for Providers portal at **Humana-Military.com**. Humana Military/ValueOptions only accepts requests via fax if the provider is not able to submit electronically.

If a civilian specialty provider refers a TRICARE patient to a subspecialist, the specialty provider must contact the patient's PCM when subspecialty care is outside of the scope of the initial referral and/or prior authorization. If required, the PCM must request a new referral and/or authorization from Humana Military.

If active (i.e., already approved) referrals and/or prior authorizations are in place, specialists can request additional visits or services directly from Humana Military. Refer to the *Health Care Management and Administration* section for more information about referral and prior authorization requirements.

**Note:** If the PCM refers a patient for a consultation only, Humana Military issues a referral for an initial consultation and one follow-up visit. Specialists cannot request additional visits or services for consult-only authorizations. The beneficiary must coordinate further care with his or her PCM. If additional services beyond the scope of the initial referral are required, the specialist must send another request to Humana Military to ensure continuity of care.

## Department of Veterans Affairs (VA) Health Care Facilities

On a case-by-case basis, the VA may contact a TRICARE network provider to request care for a VA patient or a Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiary.

CHAMPVA is the federal health benefits program for eligible family members of 100 percent totally and permanently disabled Veterans. Administered by the VA, CHAMPVA is a separate federal program from TRICARE. For questions regarding CHAMPVA, call **1-800-733-8387** or email **hac.inq@va.gov**.

For VA patients, the provider works with the referring VA Medical Center (VAMC) to coordinate health care services, medical documentation and reimbursement. The VA patient must give the TRICARE provider VAMC referral information and reimbursement instructions at the time of service. For more information or assistance, call Humana Military at **1-800-444-5445**.

## Emergency Care Responsibilities

To avoid penalties, providers must notify Humana Military of any emergency admission. Notification is available 24 hours a day, 7 days a week on **Humana-Military.com**, by calling the Interactive Voice Response (IVR) line at **1-800-444-5445** or by faxing the information to **1-877-548-1547**.

Humana Military reviews admission information and authorizes continued care, if necessary. If TRICARE Prime enrollees seek nonemergency care without required referrals and/or authorizations, they are responsible for paying POS fees. Refer to the *Medical Coverage* section for more information on emergency and urgent care services.

## Clearly Legible Reports

For care referred by an MTF, network providers must provide Clearly Legible Reports (CLRs), which include consultation reports, operative reports 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 to 10 business days.

Providers must send preliminary reports for urgent and emergency specialty care consultations to the referring provider within 24 hours (unless best medical practices dictate less time is required for a preliminary report). Network providers must follow the instructions included on the referral/authorization confirmation from Humana Military.

## Balance Billing

A TRICARE network provider agrees to accept the rates and terms of payment specified in its agreement with Humana Military as payment for a covered service. 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, only for any applicable cost-shares.

Non-network nonparticipating providers do not have to accept the TRICARE allowable charge and may bill patients for 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.

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

Medicare's balance billing limitations apply to TRICARE. Noncompliance 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. In addition, network and participating non-network providers cannot bill beneficiaries for noncovered services unless the beneficiary agrees in advance and in writing to pay for these services.

## Informing Beneficiaries about Noncovered Services

**Before** delivering care, network providers must notify TRICARE patients if services are not covered. Noncovered services include:

- Services that appear on the No Government Pay Procedure Code List, available at **www.TRICARE.mil/NoGovernmentPay**

- Services outside of the scope of TRICARE-covered services
- Services that currently have a temporary code or are still considered experimental

**Note:** Denied or rejected claims with services in the scope of coverage are not considered noncovered services.

**Note:** ADSMs may be covered for the above services on a case-by-case basis with valid authorization from their MTF.

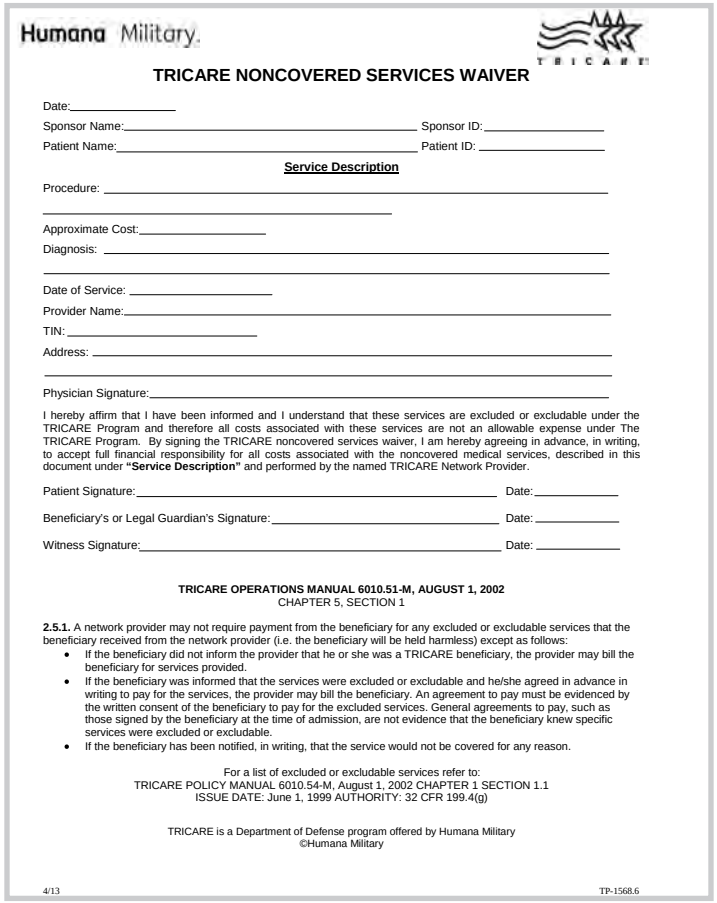
The beneficiary must agree in advance and in writing to receive and accept financial responsibility for noncovered services. The agreement must document the specific services, dates, estimated costs and other information.

Network providers **must** use the *TRICARE Noncovered Services Waiver* form 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.

If the beneficiary does not sign a *TRICARE Noncovered Services Waiver* form, the provider is financially responsible for the cost of noncovered services he or she delivers. See the *Medical Coverage* section for a summary of TRICARE-covered and noncovered services and benefits.

To download the form, search for T**RICARE Noncovered Services Waiver** at **Humana-Military.com**. Network providers should keep copies of the *TRICARE Noncovered Services Waiver* form in their offices. Figure 2.2 shows an example of this form.

## Noncovered Services Waiver Figure 2.2



Humana Military.

TRICARE

**TRICARE NONCOVERED SERVICES WAIVER**

Date:_____

Sponsor Name:_____ Sponsor ID:_____

Patient Name:_____ Patient ID: _____

**Service Description**

Procedure: _____

_____

Approximate Cost:_____

Diagnosis: _____

_____

Date of Service: _____

Provider Name:_____

TIN: _____

Address: _____

_____

Physician Signature:_____

I hereby affirm that I have been informed and I understand that these services are excluded or excludable under the TRICARE Program and therefore all costs associated with these services are not an allowable expense under The TRICARE Program. By signing the TRICARE noncovered services waiver, I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with the noncovered medical services, described in this document under **"Service Description"** and performed by the named TRICARE Network Provider.

Patient Signature:_____ Date:_____

Beneficiary's or Legal Guardian's Signature:_____ Date:_____

Witness Signature:_____ Date: _____

**TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002**
CHAPTER 5, SECTION 1

**2.5.1.** A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e. the beneficiary will be held harmless) except as follows:

- If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary, the provider may bill the beneficiary for services provided.
- If the beneficiary was informed that the services were excluded or excludable and he/she agreed in advance in writing to pay for the services, the provider may bill the beneficiary. An agreement to pay must be evidenced by the written consent of the beneficiary to pay for the excluded services. General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or excludable.
- If the beneficiary has been notified, in writing, that the service would not be covered for any reason.

For a list of excluded or excludable services refer to:
TRICARE POLICY MANUAL 6010.54-M, August 1, 2002 CHAPTER 1 SECTION 1.1
ISSUE DATE: June 1, 1999 AUTHORITY: 32 CFR 199.4(g)

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4/13 TP-1568.6

## Hold-Harmless Policy for Network Providers

A network provider may not bill a TRICARE beneficiary for excluded or excludable services (i.e., 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 the services

A TRICARE beneficiary is held harmless from financial liability for noncovered services. If the beneficiary has agreed in writing (using the *TRICARE Noncovered Services Waiver* form) in advance of the service/care being performed, the provider may bill the beneficiary directly.

If there is not a TRICARE waiver on file for the patient and the specified date of service and care, then the network provider has no recourse and must uphold the hold harmless provision according to Title 10 of the Code of Federal Regulations on TRICARE.

## An Important Message from TRICARE Form

Inpatient facilities are required to provide each TRICARE beneficiary with a copy of the *An Important Message from TRICARE* form. This document details the beneficiary's rights and obligations on admission to a hospital.

The signed document must be kept in the beneficiary's file. A new document must be provided for each admission.

To download the form, search for **Important Message** at **Humana-Military.com**.

# Updating Provider Information

Keeping information up to date ensures that Humana Military sends payments to providers' correct address and that TRICARE beneficiaries and other providers can access current contact information. All providers can update their information through **myTRICARE.com**, the website of PGBA, Humana Military's claims processing partner.

To update information, log in to **myTRICARE.com**, go to **myACCOUNT INFORMATION** and click **Manage your provider files**. Select the location to update, enter the new information, click the **Continue** button and follow the prompts.

Please note that each location has two information tabs: Physical address information and Mailing/pay to information. When making changes, don't forget to update both tabs when applicable.

For assistance, call PGBA at **1-800-403-3950**.

# TRICARE Eligibility

## Verifying Eligibility

Providers must verify TRICARE eligibility at the time of service.

Providers must ensure beneficiaries have valid Common Access Cards (CACs), uniformed services 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 files.

A CAC or ID card alone does **not** prove TRICARE eligibility. Providers must verify the card bearer's TRICARE eligibility either via Humana Military's secure Self-Service for Providers at **Humana-Military.com** or via Humana Military's toll-free Interactive Voice Response (IVR) line at **1-800-444-5445**.

Use the sponsor's Social Security Number (SSN) or Department of Defense (DoD) Benefits Number (DBN) to verify eligibility. If verifying online, retain a printout of the eligibility verification screen for files.

**Note:** 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.

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.

*CAC Card (Active Duty Only)  Figure 3.1*


## Copying Identification Cards

To prevent identity theft and protect information from being used by individuals impersonating U.S. military personnel, TRICARE beneficiaries are instructed as a general rule not 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 specific authorized purposes, which may include:

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

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

## Common Access Cards

Active Duty Service Members (ADSMs) and drilling National Guard and Reserve members carry CACs. Before providing care, check the CAC expiration date. Figure 3.1 provides an example of a CAC card.

Although CACs are valid uniformed services ID cards, they do **not**, on their own, prove TRICARE eligibility. Providers must verify patient eligibility at the time of service.

## Uniformed Services Identification Cards

The uniformed services ID card incorporates a digital photographic image of the bearer, bar codes containing pertinent machine-readable data, and printed ID and entitlement information.

Figure 3.2 on the following page offers an example of a uniformed services ID card. ID cards may vary in format according to the specific military branch.

The beneficiary category determines the ID card's color:

- **Active Duty Family Members (ADFMs):** Uniformed Services Identification and Privilege Card (DD Form 1173) — tan
- **National Guard and Reserve family members:** Department of Defense Guard and Reserve Family Member Identification Card (DD Form 1173-1) — red
- **Retirees:** United States Uniformed Services Identification Card (Retired) (DD Form 2 [RET]) — blue

- **Retiree dependents:** DD Form 1173 — tan
- **Transitional Assistance Management Program (TAMP) beneficiaries:** Department of Defense/Uniformed Services Identification and Privilege Card (DD Form 2765)—tan

ID cards may include the following information that providers will need:

- **ID numbers:** Providers should use the sponsor's SSN or DBN when verifying the card bearer's TRICARE eligibility and filing claims. New ID cards no longer include SSNs, and some may not include DBNs.

  If the card does not list the sponsor's DBN or SSN, the beneficiary will need to provide either one for eligibility verification. Do **not** use the 10-digit DoD ID number. Here is a list of possible ID numbers:

  - Sponsor's SSN — a nine-digit number no longer on ID cards, which **is** acceptable (Beneficiaries can verbally provide their sponsor's SSN.)
  - DoD ID number — a 10-digit number on ID cards, which **is not** acceptable
  - DBN — an 11-digit number on some ID cards, which **is** acceptable (**Do not include any dashes.**)

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

## 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 cards should read INDEF (i.e., indefinite) in the Expiration Date box.

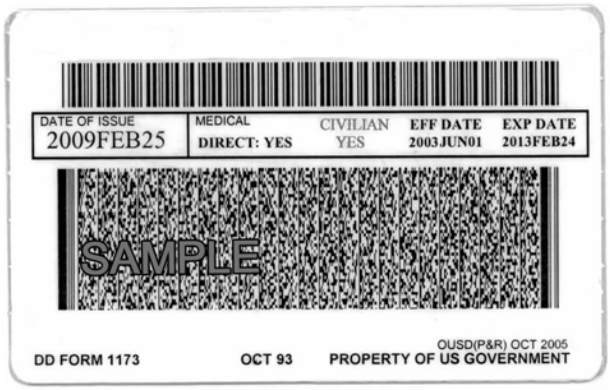
# Important Notes about Eligibility

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

ADSMs are required to enroll in TRICARE Prime; however, TRICARE Prime enrollment is not the criteria for treating an ADSM. ADSMs receive care at Military Treatment Facilities (MTFs). If civilian network care is required, the MTF will provide a referral. The Military Medical Support Office (MMSO) will coordinate care in certain circumstances.

Once the provider verifies an ADSM's TRICARE eligibility, the provider

*All Other Cards* *Figure 3.2*


may deliver care and submit the claim to Humana Military for payment. The ADSM's service branch may help coordinate ADSM care and is responsible for paying for any civilian emergency or referred health care required by ADSMs. See the *Claims Processing and Billing Information* section for additional details.

National Guard and Reserve members seeking medical care for Line-Of-Duty (LOD) injuries may appear as ineligible in DEERS if they are activated for 30 or fewer days. See *Line-Of-Duty Care for National Guard and Reserve Members* in the *TRICARE Program Options* section for more information.

# TRICARE and Medicare Eligibility

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

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

- ADFMs remain eligible for TRICARE Prime and TRICARE Standard/TRICARE Extra while the sponsor is on active duty. However, once the sponsor retires from active duty, the sponsor and his or her family members who are entitled to premium-free Medicare Part A must also have Medicare Part B to keep their TRICARE benefits.

- TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), CHCBP and US Family Health Plan (USFHP) beneficiaries are not required to have Medicare Part B to remain covered under these programs.

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

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

Beneficiaries who receive disability benefits from the SSA are entitled to Medicare in the 25th month of receiving disability payments. The Centers for Medicare and Medicaid Services (CMS) notifies beneficiaries of their Medicare entitlement date.

If a beneficiary returns to work and his or her Social Security disability payments are suspended, his or her Medicare entitlement continues for up to eight years and six months. When disability payments are suspended, beneficiaries receive a bill every three months for Medicare Part B premiums and must continue to pay Medicare Part B premiums to remain eligible for TRICARE coverage.

# Eligibility for TRICARE and Veterans Affairs Benefits

Certain beneficiaries are eligible for both TRICARE and U.S. Department of Veterans Affairs (VA) benefits programs, and they may choose which benefits they want to use. Further, a beneficiary can seek TRICARE-covered services even if he or she received treatment through the VA for the same medical condition during a previous episode of care.

However, TRICARE does not duplicate payments made or authorized by VA for service-connected disability care. Eligibility for VA health care for service-connected disabilities is not considered double coverage.

## Veterans Affairs Benefits as Other Health Insurance (OHI)

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

If beneficiaries are entitled to Medicare Part A due to age or another reason, they are considered Medicare-eligible and must have Medicare Part B to keep their TRICARE benefit. (Certain beneficiaries may not need Medicare Part B to keep their TRICARE benefit. For more information, visit **www.TRICARE.mil/TFL**.)

TRICARE beneficiaries with Medicare Part A and Part B are covered by TFL, TRICARE's Medicare-wraparound coverage. Under TFL, Medicare acts as the primary insurance, and TRICARE acts as the secondary payer.

VA care is not covered by Medicare, so if beneficiaries seek care from a VA provider while they are using their TRICARE benefit, TFL pays first, and Medicare pays nothing. In this situation, beneficiaries pay the TRICARE Standard Fiscal Year (FY) deductible, cost-shares and remaining billed charges.

Alternatively, they may choose to use their VA benefit when seeing VA providers. For beneficiaries to minimize their out-of-pocket costs once they are covered by TFL, they should seek care from providers who participate in both TRICARE and Medicare.

# Notes

# TRICARE Program Options

TRICARE offers comprehensive medical benefits to all TRICARE beneficiaries, as well as pharmacy and dental benefits. Depending on a beneficiary's status and location, he or she may be eligible for different program options. This section provides information on TRICARE program options, including the TRICARE Pharmacy Program and the TRICARE Dental Program (TDP) options.

## TRICARE Prime Coverage Options

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

In the TRICARE South Region, TRICARE Prime, TPR and TPRADFM require enrollment with Humana Military. See the *TRICARE Eligibility* section for instructions on verifying patient eligibility.

### TRICARE Prime

TRICARE Prime is a managed care option available in TRICARE Prime Service Areas (PSAs). A PSA is a geographic area where TRICARE Prime benefits are offered. It is typically an area around a Military Treatment Facility (MTF) or other predetermined areas.

ADSMs who live and work in PSAs must enroll in TRICARE Prime; however, ADFMs and other eligible beneficiaries may enroll in TRICARE Prime or use TRICARE Standard/TRICARE Extra. Each TRICARE Prime enrollee is assigned a Primary Care Manager (PCM).

Whenever possible, a PCM located at an MTF is assigned, but a TRICARE network PCM may be assigned if an MTF PCM is not available. TRICARE Prime beneficiaries should always seek nonemergency care from their PCMs unless they're using the Point-Of-Service (POS) option.

In most cases, a TRICARE Prime enrollee must obtain a referral and/or prior authorization to receive nonemergency care from a provider other than his or her PCM. All TRICARE Prime enrollees (except ADSMs) can self-refer to a network provider who is authorized under TRICARE regulations to see patients independently for behavioral health care services.

An MTF has the Right Of First Refusal (ROFR) for TRICARE Prime referrals within their catchment area for inpatient admissions, specialty appointments and procedures requiring prior authorization, provided the MTF is able to deliver the service requested by the beneficiary's civilian provider. This means TRICARE Prime enrollees must first try to obtain care at MTFs.

MTF staff members review the referral to determine if they can provide care within access standards. If the service is not available within access standards, the MTF refers the beneficiary to a TRICARE network provider.

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

TPR and TPRADFM provide TRICARE Prime coverage to ADSMs and the family members who live with them in remote locations through a network of civilian TRICARE-authorized providers, institutions and suppliers (network or non-network). ADSMs and their families who live and work more than 50 miles or a one-hour drive time from the nearest MTF designated as adequate to provide primary care may be eligible to enroll in TPR or TPRADFM.

Each TPR or TPRADFM enrollee is assigned a PCM. Whenever possible, a TRICARE network PCM is assigned, but a non-network TRICARE-authorized PCM may be assigned if a network provider is not available.

TPR and TPRADFM beneficiaries should always seek nonemergency care from their PCMs unless they're using the POS option. In most cases, a TPR or TPRADFM enrollee must obtain a referral and/or prior authorization to receive nonemergency care from another provider who is not his or her PCM.

TPR ADSMs do not need referrals, prior authorizations or fitness-for-duty reviews to receive primary care. Specialty and inpatient services require referrals and prior authorizations from Humana Military/ValueOptions and the Military Medical Support Office (MMSO) Service Point Of Contact (SPOC). The SPOC determines referral management for fitness-for-duty care.

To determine if a particular ZIP code falls within a TPR coverage area, use the ZIP code lookup tool at **www.TRICARE.mil/TPRZipCode**.

### TRICARE Prime Point-Of-Service Option

The POS option allows non-ADSMs enrolled in TRICARE Prime, TPR or TPRADFM to seek nonemergency health care services from any TRICARE-authorized provider without referrals.

The POS cost-share applies when:

- The patient receives care from a civilian TRICARE-authorized provider without an appropriate referral/authorization.
- The patient self-refers to a network specialty care provider after Humana Military authorizes a referral to see an MTF specialty care provider.

- The patient enrolled at an MTF self-refers to a civilian provider, other than his or her PCM, for routine care.
- The patient self-refers for nonemergency behavioral health care from a non-network behavioral provider. (The POS option applies to all nonemergency behavioral health care from non-network providers. Prior authorization requirements may still apply.)

The POS option does not apply to the following:

- ADSMs
- Newborns and newly adopted children in the first 60 days after birth or adoption
- Emergency care
- Clinical preventive care received from a network provider
- Behavioral health care outpatient visits to a network provider for medically necessary treatment for covered conditions by network providers who are authorized under TRICARE regulations to see patients independently
- Beneficiaries with Other Health Insurance (OHI)

When using the POS option, beneficiaries must pay a deductible and 50 percent of the TRICARE allowable charge. POS costs do not apply to the catastrophic cap.

Please note that the POS option does not affect provider reimbursement; the beneficiary pays a larger portion of the total TRICARE allowable charge. Providers should note referral end dates and advise beneficiaries when additional referrals are required. For specific inpatient costs, visit **www.TRICARE.mil/costs**.

**Note:** ADSMs may not use the POS option and must always obtain referrals and/or authorization for civilian care. If an ADSM receives care without a required referral or prior authorization, the claim is forwarded to the SPOC for payment determination.

If the SPOC approves the care, the ADSM does not have to pay the bill. If the SPOC does not approve, the ADSM is responsible for the entire cost of care.

## TRICARE Standard and TRICARE Extra

TRICARE Standard/TRICARE Extra is available to any TRICARE-eligible beneficiary with an active military ID who has not enrolled in TRICARE Prime. Beneficiaries can seek care from any TRICARE-authorized provider with no referral.

TRICARE Standard/TRICARE Extra involves cost-shares and deductibles. TRICARE Standard patients who see network providers for their care use the TRICARE Extra benefit, which lowers out-of-pocket costs.

Seeing TRICARE Standard/TRICARE Extra beneficiaries involves no drawbacks for network providers. Network providers file claims for TRICARE Standard/TRICARE Extra in the same way as for TRICARE Prime.

TRICARE Standard beneficiaries do not have PCMs and may self-refer to any TRICARE-authorized provider. However, certain services (e.g., inpatient admissions for substance abuse disorders and behavioral health, adjunctive dental care, home health services) require prior authorization from Humana Military/ValueOptions.

See the *Health Care Management and Administration* section or the *Behavioral Health Care Services* section for more information about referral and authorization requirements.

See the *TRICARE Program Options Costs* chart, included with this handbook, for specific cost information. For more cost information, visit **www.TRICARE.mil/costs**.

## Supplemental Health Care Program

TRICARE is derived from the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which technically does not cover ADSMs (or National Guard and Reserve members on active duty). However, similar to TRICARE, the Supplemental Health Care Program (SHCP) provides coverage for ADSMs (except those enrolled in TPR) and non-active duty individuals under treatment for Line-Of-Duty (LOD) conditions.

SHCP also covers health care services ordered by an MTF provider for a non-ADSM MTF patient for whom the MTF provider maintains responsibility. Although the Department of Defense (DoD) funds SHCP, it is separate from TRICARE and follows different rules.

Only the following individuals are eligible for SHCP:

- ADSMs assigned to MTFs
- ADSMs on travel status (e.g., leave, temporary assignment to duty or permanent change of station)
- 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 and Reserve members (LOD care only, unless member is on active federal service)
- National Oceanic and Atmospheric Administration personnel, U.S. Public Health Service personnel, cadets or midshipmen, and eligible foreign military personnel
- Non-active duty beneficiaries when they are inpatients in an MTF and are referred to 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
- Comprehensive Clinical Evaluation Program participants
- Beneficiaries on the Temporary Disability Retirement List required to obtain periodic physical examinations
- Medically retired former members of the armed services enrolled in the Federal Recovery Coordination Program

Providers can verify SHCP patient eligibility via Humana Military's secure Self-Service for Providers at **Humana-Military.com** or via Humana Military's toll-free Interactive Voice Response (IVR) line at **1-800-444-5445**.

SHCP covers care referred or authorized by the MTF and/or the MMSO. When SHCP beneficiaries need care, the MTF (if available) or the MMSO refers ADSMs and certain other patients to civilian providers.

If services are unavailable at the MTF, the *Referral for Civilian Medical Care* form (DD Form 2161) is sent to Humana Military before the patient receives specialty care. (The form may vary by MTF site.) Humana Military and the MTF, as appropriate, identify a civilian provider and notify the patient. For non-MTF referred care, the SPOC determines if the ADSM receives care from an MTF or civilian provider.

SHCP beneficiaries are not responsible for cost-shares, copays or deductibles. See the *Claims Processing and Billing Information* section for SHCP claims submission information.

# Warrior Navigation and Assistance Program

Humana Military created the Warrior Navigation and Assistance Program (WNAP) to support ADSMs and National Guard and Reserve members, their families and their providers. The program provides information and assistance to help combat veterans — ADSMs, National Guard and Reserve members, and medically retired service members — navigate military health care systems, the Department of Veterans Affairs (VA) health systems, community resources and the civilian health care sector.

WNAP offers person-to-person guidance and access to an advocacy unit specially trained to handle the unique challenges many wounded, ill and injured warriors face in accessing care. The program provides warriors and their families with resources that can help them return to healthy and productive lives.

For more information, visit **Humana-Military.com/WNAP** or call **1-888-4GO-WNAP** (**1-888-446-9627**).

# TRICARE For Life

TRICARE For Life (TFL) is Medicare-wraparound coverage for dual-eligible TRICARE beneficiaries. Regardless of age, beneficiaries are considered dual-eligible if they are entitled to premium-free Medicare Part A and eligible for TRICARE because they also have Medicare Part B coverage.

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

TFL provides comprehensive health care coverage. Beneficiaries have the freedom to seek care from any Medicare-participating provider, from MTFs on a space-available basis or from VA facilities (if eligible).

Medicare cannot pay for services received from the VA. Therefore, TRICARE is the primary payer for VA claims, and the beneficiary will be responsible for the TRICARE annual deductible and cost-shares.

Alternatively, the beneficiary may choose to use his or her VA benefit. Neither TRICARE nor Medicare will reimburse costs not covered by the VA.

Medicare-participating providers file claims with Medicare first. After paying its portion, Medicare automatically forwards the claim to TFL for processing (unless the beneficiary has OHI). TFL pays after Medicare and any OHI for covered health care services.

All beneficiaries should sign up for Medicare Part B as soon as they become eligible to avoid a break in TRICARE coverage.

TFL beneficiaries must present valid uniformed services identification (ID) cards and Medicare cards prior to receiving services. If a TFL beneficiary's uniformed services ID card reads NO under the Civilian box, 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 files.

There is no separate TFL enrollment card. To verify TFL eligibility, call the TFL contractor, Wisconsin Physicians Service/TRICARE Dual Eligible Fiscal Intermediary Contract (WPS/TDEFIC), at **1-866-773-0404**. Call the Social Security Administration (SSA) 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 PSAs) or TRICARE Standard/TRICARE Extra.

See *TRICARE and Medicare Eligibility* in the *TRICARE Eligibility* section for more information.

## How TRICARE for Life Works

Because Medicare is the primary payer, referrals and prior authorizations from Humana Military are usually not required. However, dual-eligible beneficiaries may need an authorization from Humana Military/ValueOptions if Medicare benefits are exhausted or for care covered by TRICARE but not Medicare. See the *Health Care Management and Administration* section for more information about TRICARE referral and authorization requirements.

File TFL claims first with Medicare. Medicare pays its portion and electronically forwards the claim to WPS/TDEFIC (unless the beneficiary has OHI). WPS/TDEFIC sends its payment for TRICARE-covered services directly to the provider. Beneficiaries receive Medicare Summary Notices and TRICARE Explanations Of Benefits (EOBs) 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 for information about TFL claims and coordinating with OHI. For more information about TFL, call WPS/TDEFIC at **1-866-773-0404** or visit **www.TRICARE4u.com**.

# TRICARE for the National Guard and Reserve

The seven National Guard and Reserve components include:

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

## TRICARE Reserve Select (TRS)

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

TRS members may self-refer to any TRICARE-authorized provider; however, certain services (e.g., inpatient admissions for substance use disorders and behavioral health care, adjunctive dental care, home health services) require prior authorization from Humana Military. See the *Health Care Management and Administration* section for more information about referral and authorization requirements.

After purchasing either member-only or member-and-family TRS coverage, TRS members receive TRS 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. Copy both sides of the cards and retain the copies for files. See the *TRICARE Eligibility* section for information on verifying patient eligibility.

For more information, visit the TRS website at **www.TRICARE.mil/TRS** or call **1-877-298-3408**, menu option 1.

## TRICARE Retired Reserve (TRR)

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

TRR members may self-refer to any TRICARE-authorized provider; however, certain services (e.g., inpatient admissions for substance use disorders and behavioral health care, adjunctive dental care, home health services) require prior authorization from Humana Military. See the *Health Care Management and Administration* section for more information about referral and authorization requirements.

After purchasing either member-only or member-and-family TRR coverage, TRR members receive TRR enrollment cards. These cards include important contact information but are not required to obtain care.

Although beneficiaries should expect to present their cards at the time of service, enrollment cards do **not** verify TRICARE eligibility. Copy both sides of the cards and retain the copies for files. See the *TRICARE Eligibility* section for information on verifying patient eligibility.

For more information, visit the TRR website at **www.TRICARE.mil/TRR** or call **1-877-298-3408**, menu option 1.

## Line-Of-Duty (LOD) Care for National Guard and Reserve Members

An 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 status. This includes the time period when the member is traveling directly to or from the location where he or she performs military duty. The National Guard or Reserve member's service determines eligibility for LOD care, and the member receives a written authorization that specifies the LOD condition and terms of coverage.

**Note:** The Defense Enrollment Eligibility Reporting System (DEERS) does not show eligibility for LOD care.

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

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

- Coverage under the TRS program option

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

Humana Military forwards any claim not referred by an MTF or preapproved by the MMSO to the MMSO for approval or denial. The provider should submit medical claims directly to Humana Military unless otherwise specified in the LOD written authorization or requested by the National Guard or Reserve member's medical department representative. When submitting claims for a National Guard or Reserve member with an LOD condition, the services listed on the claim must be directly related to the condition documented in the LOD written authorization.

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

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

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

Family members of National Guard and Reserve members may also 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 TPRADFM, depending on location, or they may use TRICARE Standard/TRICARE Extra. They are also eligible for dental coverage through TDP. Sponsors must register their family members in DEERS to establish TRICARE eligibility.

## TRICARE Young Adult Program

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

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

- A dependent of an eligible uniformed services sponsor (If the beneficiary is an adult child of a nonactivated member of the Selected Reserve of the Ready Reserve or of the Retired Reserve, his or her sponsor must be enrolled in TRS or TRR to be eligible to purchase TYA coverage.)
- Unmarried
- At least age 21 (or age 23 if enrolled in a full-time course of study at an approved institution of higher learning and if the sponsor provides more than 50 percent of the financial support) but have not yet reached age 26
- Not eligible to enroll in an employer-sponsored health plan as defined in TYA regulations
- Not otherwise eligible for TRICARE program coverage

## 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. To fill prescriptions, beneficiaries need written prescriptions and valid uniformed services ID cards or Common Access Cards (CACs).

TRICARE beneficiaries have the following options for filling prescriptions:

- **MTF pharmacies:** Using an MTF pharmacy is the least expensive option, but formularies may vary by MTF pharmacy location. Contact the local MTF pharmacy to check availability before prescribing a medication.
- **TRICARE Pharmacy Home Delivery:** TRICARE Pharmacy Home Delivery (formerly TRICARE Mail Order Pharmacy) is the preferred method when not using an MTF pharmacy.
- **TRICARE retail network pharmacies:** Beneficiaries can access a network of approximately 60,000 retail pharmacies in the United States and U.S. territories (American Samoa,* Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands).
- **Non-network retail pharmacies:** Filling prescriptions at a non-network retail pharmacy is the most expensive option and is not recommended to beneficiaries.

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

All prescriptions filled through TRICARE Pharmacy Home Delivery must have the prescriber's handwritten signature. For more information about benefits and costs, visit **www.TRICARE.mil/pharmacy** or **www.express-scripts.com/TRICARE**, or call Express Scripts at **1-877-363-1303**.

**Note:** US Family Health Plan (USFHP) participants may only use the pharmacy benefits provided under that program.

### Member Choice Center

The Member Choice Center helps TRICARE beneficiaries transfer their current retail and MTF pharmacy maintenance medication prescriptions to home delivery. If one of a provider's patients uses the Member Choice Center, an Express Scripts patient-care advocate may contact the provider for patient and prescription information.

To learn more about the Member Choice Center, call Express Scripts at **1-877-363-1303**, or visit **www.TRICARE.mil/pharmacy** or **www.express-scripts.com/TRICARE**.

## Generic Drug Use Policy

It is a 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 a patient requires a brand-name medication that has a generic equivalent, the provider 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.

## Quantity Limits

TRICARE has established quantity limits on certain medications, which means the DoD only pays for up to a specified, limited 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. Visit **www.pec.ha.osd.mil/formulary_search.php** for a general list of TRICARE-covered prescription drugs that have quantity limits.

## Prior Authorizations

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

For a general list of TRICARE-covered prescription drugs requiring prior authorization and to access prior authorization and medical necessity criteria forms for retail network pharmacy and home delivery prescriptions, visit **www.pec.ha.osd.mil/formulary_search.php**. MTF 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**.

## Uniform Formulary Drugs and Non-Formulary Drugs

In 2005, the DoD established a uniform formulary, which is a list of covered generic and brand-name drugs. The formulary also contains a third tier of medications designated as "non-formulary."

The DoD Pharmacy and Therapeutics Committee may recommend to the director of the TRICARE Management Activity (TMA) that certain drugs be placed in the non-formulary tier. These medications include any drug in a therapeutic class determined to be not as clinically effective or as cost-effective as other drugs in the same class.

For a higher copay, third-tier drugs are available through TRICARE Pharmacy Home Delivery or retail network pharmacies. A beneficiary may be able to fill a non-formulary prescription at formulary costs if the provider can establish medical necessity by submitting the appropriate TRICARE Pharmacy Program medical necessity form to Express Scripts for the non-formulary medication. To download the form, visit **www.pec.ha.osd.mil/forms_criteria.php**.

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

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

- Use of the formulary alternative is contraindicated.
- The 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 **www.pec.ha.osd.mil/forms_criteria.php** for forms and medical necessity criteria. To learn more about medications and common drug interactions, check for generic equivalents or determine if a drug is classified as a non-formulary medication, visit the TRICARE Formulary Search Tool at **www.pec.ha.osd.mil/formulary_search.php**.

## Step Therapy

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

Drugs subject to step therapy will only be approved for first-time users after they have tried one of the preferred agents on the DoD uniform formulary (e.g., a patient must try omeprazole or Nexium®

prior to using any other proton pump inhibitor).

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

## Pharmacy Benefits for Medicare-Eligible Beneficiaries

TRICARE beneficiaries who were entitled to Medicare Part A prior to April 1, 2001, remain eligible for TRICARE pharmacy benefits without the requirement to have Medicare Part B. Medicare-eligible beneficiaries are able to use the TRICARE Pharmacy Program if they are entitled to Medicare Part A and have Part B.

If they do not have Medicare Part B, they may only access pharmacy benefits at MTFs. (Exceptions exist for certain beneficiaries, including ADSMs and ADFMs. Please see *TRICARE For Life* earlier in this section for more information.)

Medicare-eligible beneficiaries are also eligible for Medicare Part D prescription drug plans. However, beneficiaries do not need to enroll in a Medicare Part D plan to keep their TRICARE Pharmacy Program benefits.

Providers can direct eligible beneficiaries who inquire about Medicare Part D coverage to visit the TRICARE website at **www.TRICARE.mil/MedicarePartD**. For the most up-to-date information on the Medicare Part D prescription drug benefit, beneficiaries should call Medicare at **1-800-MEDICARE** (**1-800-633-4227**) or visit **www.medicare.gov**.

## Specialty Medication Care Management

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

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

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

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

Beneficiaries enrolled in the Specialty Medication Care Management program have access to pharmacists 24 hours a day, seven days a week. The specialty clinical team contacts the beneficiaries' physicians, as needed, to address beneficiary issues such as side effects or disease exacerbations. If any patients currently fill specialty medication prescriptions at retail pharmacies, the specialty clinical team will provide brochures detailing the program as well as prepopulated enrollment forms.

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

**Note:** Some specialty medications may not be available through TRICARE Pharmacy Home Delivery because the manufacturer limits the drug's distribution to specific pharmacies. If providers submit a prescription for a limited-distribution medication, TRICARE Pharmacy Home Delivery either forwards the prescription to a pharmacy of the patient's choice that can fill it or provides the patient with instructions about where to send the prescription. To determine if a specialty medication is available through TRICARE Pharmacy Home Delivery, visit **www.pec.ha.osd.mil/formulary_search.php**.

# TRICARE Dental Options

The TRICARE health care benefit covers adjunctive dental care (i.e., dental care that is medically necessary to treat a covered medical condition). However, several non-adjunctive dental care options are available to eligible beneficiaries.

ADSMs receive dental care at military Dental Treatment Facilities (DTFs) or from civilian providers through the TRICARE Active Duty Dental Program (ADDP) if necessary. For all other beneficiaries, TRICARE offers two premium-based dental programs: the TRICARE Dental Program (TDP) or the TRICARE Retiree Dental Program (TRDP). Each program is administered by a separate dental contractor and has its own monthly premiums and cost-shares.

**Note:** TRICARE may cover some medically necessary services in conjunction with noncovered or non-adjunctive dental treatment for patients with developmental, mental or physical disabilities and for children age 5 years and younger. See the *Medical Coverage* section for more details.

## TRICARE Active Duty Dental Program

United Concordia Companies, Inc. administers ADDP and provides civilian dental care to ADSMs who are referred for care

by a military DTF or who serve on active duty and reside more than 50 miles from a DTF. Visit **www.ADDP-UCCI.com** or **www.TRICARE.mil/dental** for more information.

### TRICARE Dental Program

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.

ADSMs (and National Guard and Reserve members called to active duty for a period of more than 30 consecutive days or eligible for the preactivation benefit up to 180 days prior to their report date) are not eligible for TDP. They receive dental care at military DTFs or through ADDP.

For more information, visit **https://mybenefits.metlife.com/TRICARE** or call MetLife at **1-855-MET-TDP1** (**1-855-638-8371**).

### TRICARE Retiree Dental Program

TRDP, administered by Delta Dental® of California, is a voluntary dental insurance program available to uniformed services retirees and their eligible family members, retired National Guard and Reserve members (including those who are entitled to retired pay but will not begin receiving it until age 60) and their eligible family members, certain surviving family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors.

For more information, visit **www.TRDP.org** or call Delta Dental at **1-888-838-8737**.

## Cancer Clinical Trials

The DoD Cancer Prevention and Treatment Clinical Trials Demonstration was conducted from 1996 through March 2008 to improve access to promising new cancer therapies, assist in meeting the National Cancer Institute (NCI) clinical trial goals and assist in developing conclusions about the safety and efficacy of emerging cancer prevention and treatment therapies.

Effective April 1, 2008, participation in cancer clinical trials was adopted as a permanent TRICARE benefit. TRICARE beneficiaries who began participation in the demonstration project prior to its termination will continue to receive services as demonstration participants until discharged from the clinical trial.

There are three types of NCI clinical trials:

- Phase I trials: TRICARE beneficiaries may be eligible to participate in Phase I trials if they meet certain requirements.
- Phase II trials: TRICARE beneficiaries may participate in Phase II trials, which study the safety and effectiveness of an agent or intervention on a particular type of cancer and evaluate how it affects the human body.
- Phase III trials: TRICARE beneficiaries may also participate in Phase III trials, which compare promising new treatments against standard approaches. These studies also focus on particular types 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. Providers must contact a case manager before beginning the evaluation or any treatment under the clinical trial.

For more information, call Humana Military at **1-800-444-5445**. NCI's website at **www.cancer.gov** lists some, but not all, of the Phase I, Phase II and Phase III NCI-sponsored clinical trials.

## TRICARE Extended Care Health Option

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

Potential ECHO beneficiaries must be ADFMs, have qualifying conditions and be registered in the Exceptional Family Member Program (EFMP). Each service branch has its own EFMP and enrollment process.

Under certain circumstances, this requirement may be waived. To learn more, contact the beneficiary's service branch's EFMP representative or visit **www.TRICARE.mil**. A record of ECHO registration is stored with the beneficiary's DEERS information.

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

- Moderate or severe mental retardation
- Serious physical disability

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

**Note:** Active duty sponsors with family members seeking ECHO registration **must** enroll in their service branch's EFMP — unless waived in specific situations — and register to be eligible for ECHO benefits. There is no retroactive registration for the ECHO program. Visit **www.MilitaryOneSource.mil/EFMP** for more information about EFMP.

## 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 the ECHO benefit.

Refer patients to Humana Military for assistance with eligibility determination and ECHO registration. This ensures that the beneficiary and provider have a complete understanding of the benefit and have taken the necessary steps for efficient claims processing.

Providers must obtain prior authorization for all ECHO services, and they may be requested to provide medical records or assist beneficiaries with completing EFMP documents. Network and participating non-network providers must submit ECHO claims to PGBA, Humana Military's claims processing partner. For information about submitting ECHO claims, see the *Claims Processing and Billing Information* section.

In addition, providers rendering Applied Behavior Analysis (ABA) must be:

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

Note: Under the DoD Enhanced Access to Autism Services Demonstration, non-certified paraprofessional providers may render certain educational intervention services and ABA under close supervision. For more information, see DoD Enhanced Access to Autism Services Demonstration later in this section.

** If state licensure or certification is not available, providers must be certified by the Behavior Analyst Certification Board™ as either Board Certified Behavior Analysts or Board Certified Assistant Behavior Analysts.*

## ECHO Benefits

ECHO provides coverage for the following products and services:

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

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

**Note:** All ECHO services require prior authorization from Humana Military/ValueOptions. See the *Health Care Management and Administration* section for information about ECHO prior authorization requirements in the South Region.

## ECHO Costs

The government's limit for the cost of ECHO services combined (excluding EHHC) is $36,000 per beneficiary per Fiscal Year (FY). Beneficiaries are responsible for ECHO cost-shares in addition to cost-shares for basic TRICARE benefits (e.g., under TRICARE Prime, TPRADFM, TRICARE Standard/TRICARE Extra).

ECHO cost-shares do not count toward the catastrophic cap. EHHC costs do not count toward ECHO yearly maximum cost-shares.

For more information about ECHO, refer to the *TRICARE Policy Manual*, Chapter 9 at **http://manuals.tricare.osd.mil**, visit **www.TRICARE.mil/ECHO**, search for **ECHO** at **Humana-Military.com** or call ValueOptions at **1-866-323-7155**.

# DoD Enhanced Access to Autism Services Demonstration

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

This 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 (BACB)
- That state licensure and certification requirements, where applicable, are being met

The Enhanced Access to Autism Services Demonstration allows noncertified paraprofessional providers or tutors to provide ABA services under the supervision of TRICARE-authorized certified therapists to eligible ADFMs in the United States. The demonstration is effective for services provided on and between March 15, 2008 and March 14, 2014.

Noncertified tutors may provide ABA services under close supervision. Authorized supervisors are required to direct and oversee tutors who provide "hands-on" work and must verify that tutors are trained and able to perform the services required to treat individuals with autism.

**Note:** Allowed costs for Enhanced Access to Autism Services Demonstration services count toward the ECHO cost limit of $36,000 per beneficiary per FY. Visit the ECHO website at **www.TRICARE.mil/ECHO** for details.

Before recommending a person for enrollment in the Enhanced Access to Autism Services Demonstration, confirm the following beneficiary eligibility requirements:

- At least 18 months of age
- Enrolled in ECHO
- Diagnosis made by a TRICARE-authorized PCM who is a board-certified physician or a TRICARE-authorized PhD clinical psychologist working primarily with children
- Diagnosed with:
  - Autistic Disorder
  - Childhood Disintegrative Disorder
  - Asperger's Syndrome
  - Rett's Disorder
  - Pervasive developmental disorder not otherwise specified
- Provide ValueOptions with the beneficiary's Individualized Family Service Plan or the Individualized Education Program (IEP) documenting that the beneficiary is receiving early intervention services or special education, respectively. If the child is homeschooled or enrolled in a private school and not required by state law to have an IEP, the PCM or specialized Autism Services Demonstration provider must certify to Humana Military that the child requires participation in the demonstration.

For care to be authorized, a Behavior Plan (BP) must be submitted to the case manager and must include the following:

- Beneficiary's name, date of birth, date of completed Functional Behavioral Assessment and Analysis, sponsor's Social Security Number (SSN) or DoD Benefits Number (DBN), and name of referring provider
- Background and history that clearly demonstrates the condition, diagnosis, family history, length of time the beneficiary has been receiving EIA services and identification of any services/therapies received through community resources
- Plan for how the EIA supervisor will coordinate EIA services with available community services
- Goals providing a detailed description of the targeted skills and behaviors that will be addressed through EIA sessions and the objectives that will be measured
- Administration of any diagnostic tests to assess skill acquisition or behavior modification
- Frequency and method of assessing progress
- Extent of parental training to implement and reinforce skills and behaviors and to provide support for implementing strategies within a specified setting

After the initial authorization of EIA services, ongoing care must also be authorized. At least every six months, or as specified by the case manager, an updated BP with an EIA Progress Report must be submitted that includes the following:

- Beneficiary's name, date of birth, inclusive dates of the evaluation period, sponsor's SSN or DBN, and name of referring provider
- Summary of progress
- Summary of challenges to meet goals and objectives
- Parent/caregiver participation in implementing the BP during the evaluation period
- Detailed review/update of all BP elements
- Dates of the plan being updated

- Number of EIA hours of service to be provided each month by the EIA supervisor and the EIA tutor

EIA supervisors are responsible to ensure the BP is being administered by the tutor in an effective manner. The EIA supervisors must provide no less than two hours of supervision per month for each beneficiary seen by a contracted or employed tutor.

This supervision is to confirm that the quality of services provided by EIA tutors meet the minimum evidence-based standards as indicated by the current BACB task list, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, and current BACB rules and regulations.

Providers must ensure ongoing compliance with all participation requirements and report to ValueOptions within 30 days of notification any BACB sanctions for any violations or loss of BACB certification. At intervals specified by ValueOptions, EIA supervisors must cooperate with participation criteria compliance and quality of care and service audits.

For more information about the Enhanced Access to Autism Services Demonstration, refer to the *TRICARE Operations Manual*, Chapter 18, Section 8 at **http://manuals.tricare.osd.mil**, visit **www.TRICARE.mil/AutismDemo** or call ValueOptions at **1-866-323-7155**.

# Transitional Health Care Benefits

TRICARE offers three program options for beneficiaries separating from active duty: the Transitional Assistance Management Program (TAMP), the Transitional Care for Service-Related Conditions (TCSRC) program and the Continued Health Care Benefits Program (CHCBP).

## Transitional Assistance Management Program

TAMP provides 180 days of transitional health care benefits to help certain armed 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 PSA, or they are automatically covered under TRICARE Standard/TRICARE Extra. Rules and processes for these programs apply, and beneficiaries are responsible for ADFM costs.

TAMP beneficiaries must present valid uniformed services ID cards or CACs at the time of service. See the *TRICARE Eligibility* section for information about verifying eligibility.

For more information, visit **www.TRICARE.mil/TAMP**.

**Note:** TAMP does not cover LOD care. See *Line-Of-Duty Care for National Guard and Reserve Members* earlier in this section.

## Transitional Care for Service-Related Conditions Program

The Transitional Care for Service-Related Conditions (TCSRC) program extends TRICARE coverage for qualified former ADSMs diagnosed with service-related conditions during their 180-day TAMP period.

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

- Service-related
- Newly discovered or diagnosed during the 180-day TAMP period
- Able to be resolved within 180 days
- Validated by a DoD physician

The TCSRC benefit covers care only for the specific service-related condition. Preventive and health maintenance care is not covered.

TCSRC beneficiaries may seek care at MTFs or from TRICARE-authorized civilian providers if MTF care is not available. There are no copays or cost-shares under TCSRC, and providers must submit claims to Humana Military. The TCSRC benefit is available worldwide.

For more information, visit **www.TRICARE.mil/TCSRC**.

## Continued Health Care Benefit Program

CHCBP is a premium-based health care program administered by Humana Military. CHCBP offers temporary transitional health care coverage (18 to 36 months) after TRICARE eligibility ends.

CHCBP acts as a bridge between military health care benefits and the beneficiary's new civilian health care plan. CHCBP benefits are comparable to TRICARE Standard/TRICARE Extra, but differences do exist.

The main difference is that beneficiaries must pay quarterly premiums. In addition, under CHCBP, providers are not required to use or coordinate with MTFs, and MTF Nonavailability Statements (NAS) are no longer required.

Providers must coordinate with Humana Military to obtain referrals and authorizations for CHCBP beneficiaries. Providers must seek authorization for care that is deemed medically necessary. Medical necessity rules for CHCBP beneficiaries follow TRICARE Standard/TRICARE Extra guidelines.

To coordinate CHCBP referrals and authorizations, call Humana Military at **1-800-444-5445** or fax information to **1-877-270-9113**. For behavioral health CHCBP referrals and authorizations, contact ValueOptions at **1-800-700-8646** or fax information to **1-866-811-4422**.

Humana Military issues beneficiaries a CHCBP ID card after enrollment is completed. This card is different from a uniformed services ID card or a CAC, which may no longer be valid.

For more information about CHCBP, including eligibility verification, search for **CHCBP** at **Humana-Military.com** or call **1-800-444-5445**.

# Notes

# Medical Coverage

This is an overview of TRICARE-covered services and includes specific details about certain benefits. **This section is not all-inclusive.**

For additional information or answers to specific questions about TRICARE-covered services, visit **Humana-Military.com**. In addition, providers can consult the *TRICARE Policy Manual*, the *TRICARE Reimbursement Manual* or the *TRICARE Operations Manual*, available at **http://manuals.tricare.osd.mil**.

The Military Medical Support Office (MMSO) may authorize services for Active Duty Service Members (ADSMs) that are not regular TRICARE benefits. Providers must obtain prior authorization from Humana Military for these services to ensure reimbursement. See the *Health Care Management and Administration* section for information about prior authorization requirements in the South Region.

## Clinical Preventive Services

Clinical preventive care is not diagnostic but is intended to maintain and promote good health. Clinical preventive services are not related directly to specific illnesses, injuries, symptoms or obstetrical care; they are performed as periodic health screenings, health assessments or health-maintenance visits.

Beneficiaries may receive services during acute and chronic care visits or during preventive care visits for asymptomatic patients. Coverage may vary according to beneficiary type, age and program option.

TRICARE Prime enrollees do not need referrals and/or prior authorizations for clinical preventive services from Military Treatment Facility (MTF) or network providers, but they do need referrals and/or authorizations to visit non-network providers. All ADSMs, except for TRICARE Prime Remote (TPR)-enrolled ADSMs visiting their PCMs, must obtain referrals and prior authorizations to receive clinical preventive services.

TRICARE Prime and TRICARE Standard/TRICARE Extra beneficiaries have no out-of-pocket copays or cost-shares for covered clinical preventive services.

Figure 5.1 provides an overview of covered clinical preventive services. **Note:** The information included in this figure is **not** all-inclusive.

For more information on clinical preventive services, refer to the *TRICARE Policy Manual*, Chapter 7, Sections 2.1 and 2.2 at **http://manuals.tricare.osd.mil**.

## TRICARE Covered Clinical Preventive Services — Figure 5.1

| Service | Procedures and Frequency Limitations |
|---|---|
| **Cancer Screenings** | **Colonoscopy:** Individuals at average risk for colon cancer are covered once every 10 years beginning at age 50.<br><br>For individuals with increased risk, a colonoscopy is performed every two years beginning at age 25 or five years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier. Screenings are performed annually after age 40 for individuals with hereditary non-polyposis colorectal cancer syndrome.<br><br>Individuals with familial risk of sporadic colorectal cancer (i.e., individuals with first-degree relatives with sporadic colorectal cancer or adenomas before age 60 or multiple first-degree relatives with colorectal cancer or adenomas) may receive a colonoscopy every three to five years beginning at an age 10 years earlier than the youngest affected relative.<br><br>**Fecal Occult Blood Testing (FOBT):** Individuals are covered once every 12 months (either guaiac-based testing or immunochemical-based testing) beginning at age 50. At least 11 months must pass following the month of the last covered FOBT.<br><br>**Magnetic Resonance Imaging (MRI) breast screenings:** Asymptomatic women age 30 or older considered to be at high risk of developing breast cancer per the guidelines of the American Cancer Society (ACS) may receive an MRI breast screening annually. These guidelines include women who meet one of the following conditions:<br><br>• A known BRCA1 or BRCA2 gene mutation<br>• A first-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation who have not had genetic testing themselves<br>• History of radiation to the chest between the ages of 10 and 30<br>• History of Li-Fraumeni, Cowden or Hereditary Diffuse Gastric Cancer Syndrome or a first-degree relative with a history of one of these syndromes |

# TRICARE Covered Clinical Preventive Services — Figure 5.1

| Service | Procedures and Frequency Limitations |
|---|---|
| **Cancer Screenings** | **Mammograms:** Women over age 39 are covered for annual screening mammograms. High-risk women (i.e., family history of breast cancer in a first-degree relative) can receive a baseline mammogram at age 35 and then annually.<br><br>**Proctosigmoidoscopy or sigmoidoscopy**: Beneficiaries are covered once every three to five years beginning at age 50.<br><br>**Prostate cancer:** All men are covered for an annual digital rectal examination beginning at age 50. Annual exams are also covered for men with a family history of prostate cancer in at least one other family member beginning at age 45, all African-American men regardless of family history beginning at age 45 and men with a family history of prostate cancer in two or more other family members beginning at age 40.<br><br>An annual **Prostate Specific Antigen (PSA)** screening is covered for all men beginning at age 50, men with a family history of prostate cancer in at least one other family member beginning at age 45, all African-American men regardless of family history beginning at age 45 and men with a family history of prostate cancer in two or more other family members beginning at age 40.<br><br>**Routine Pap smears:** Women are covered annually beginning at age 18 (or younger if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may then decrease at the discretion of the patient and clinician, but not less frequently than every three years.<br><br>**Skin cancer:** Individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions should receive regular skin examinations. |
| **Cardiovascular** | **Blood pressure screenings:** Children ages 3 to 6 should receive annual screenings. Children over age 6 and adults should receive screenings at a minimum of every two years.<br><br>**Cholesterol test:** TRICARE covers age-specific periodic lipid panels as recommended by the National Heart, Lung, and Blood Institute (NHLBI). Refer to NHLBI's website for current recommendations: **www.nhlbi.nih.gov/guidelines**<br><br>**Abdominal Aortic Aneurysm (AAA)**: Men ages 65 to 75 who have ever smoked may receive a one-time AAA screening by ultrasonography. |
| **Hearing** | All high-risk neonates (as defined by the Joint Committee on Infant Hearing) should undergo audiology screening before leaving the hospital. If not tested at birth, high-risk children should be screened before 3 months of age. Evaluate hearing of all children as part of routine examinations, and refer those with possible hearing impairment as appropriate. |
| **Immunizations** | TRICARE covers age-appropriate doses of vaccines recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC Morbidity and Mortality Weekly Report (MMWR). Refer to the CDC's website for the current schedule of CDC-recommended vaccines: **www.CDC.gov**<br><br>Immunizations required for ADFMs whose sponsors have permanent change of station orders to overseas locations are also covered. |
| **Infectious Disease** | **Tuberculosis screening**: TRICARE covers annual screenings, regardless of age, for all high-risk individuals (as defined by CDC) using Mantoux tests.<br><br>**Rubella antibodies**: TRICARE covers a one-time screening for females ages 12 to 18, unless there's a documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday.<br><br>**Hepatitis B screening**: Screen pregnant women for HBsAG during the prenatal period. |
| **Vision** | TRICARE may cover routine and comprehensive eye exams not related to another medical or surgical condition. Vision coverage varies based on beneficiary status, program option and age. |
| **Other** | **Pediatric blood lead**: TRICARE covers assessment of risk for lead exposure by structured questionnaire based on the CDC's *Preventing Lead Poisoning in Young Children* (October 1991) during each well-child visit from age 6 months through 6 years. TRICARE covers screenings by blood lead level determination for all children at high risk for lead exposure per CDC guidelines. |

# Outpatient Services

## Adjunctive Dental Care

TRICARE covers adjunctive dental care when it's medically necessary to treat a covered medical (not dental) condition, is an integral part of the treatment of such medical condition or is required in preparation for, or as the result of, dental trauma that may be or is caused by medically necessary treatment of an injury or disease.

Acute anxiety, behavioral issues, need for extensive treatment or need for sedation/anesthesia does not alone qualify a patient for adjunctive dental care coverage. All adjunctive dental care requires prior authorization except in emergency situations such as treating facial injuries resulting from a car accident.

TRICARE may cost-share certain medically necessary care for the following conditions:

- Intraoral abscesses
- Extraoral abscesses
- Cellulitis and osteitis
- Facial trauma requiring removal of teeth or tooth fragments
- Myofascial pain dysfunction syndrome
- Total or complete ankyloglossia
- Severe congenital anomaly
- Iatrogenic dental trauma
- Dental metal amalgam/alloy hypersensitivity

TRICARE may cover certain hospital services and supplies for a patient who requires a hospital setting for noncovered, non-adjunctive dental care. If a pediatric patient age 5 or younger or a patient with a developmental, mental or physical disability requires dental procedures under general anesthesia, the dentist may submit the prior authorization request. The attending dentist cannot provide general anesthesia; a separate anesthesiology provider must administer anesthesia.

Humana Military may only authorize facility fees, medical-supply coverage, anesthesiology services and professional medical services related to the medical condition. TRICARE does not cover professional fees for non-adjunctive dental care.

The TRICARE medical benefit does not cover non-adjunctive dental care, which refers to any routine, preventive, restorative, prosthodontic, periodontic or emergency dental care not related to a medical condition.

Eligible TRICARE beneficiaries may receive non-adjunctive dental services at military Dental Treatment Facilities (DTFs) or if enrolled in one of the three TRICARE dental programs: the TRICARE Active Duty Dental Program (ADDP), the TRICARE Dental Program (TDP) or the TRICARE Retiree Dental Program (TRDP).

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

## Ambulance Services

TRICARE only covers nonemergency medical transportation when provided by an ambulance service and is medically necessary in connection with (a) otherwise covered services and supplies and (b) a covered medical condition.

TRICARE covers nonemergency ambulance transportation for the following:

- Transfers between hospitals
- Transfers from a hospital-based emergency room to a hospital more capable of providing the required care
- Transfers between a hospital or Skilled Nursing Facility (SNF) and another hospital-based or freestanding outpatient therapeutic or diagnostic department/facility

In addition, TRICARE may cover transportation of an institutionalized Extended Care Health Option (ECHO) beneficiary to or from a facility or institution to receive authorized ECHO benefits.

TRICARE only covers air or boat ambulances 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 patient's medical condition warrants speedy admission or is such that transfer by other means is not advisable.

TRICARE does not cover transportation in the following circumstances:

- Use of an ambulance service instead of a taxi service when the patient's condition would have permitted use of regular private transportation
- Transport or transfer of a patient primarily for the purpose of having the patient nearer to home, family, friends or a personal physician
- Medicabs or ambicabs that function primarily as public passenger conveyances transporting patients to and from their medical appointments

**Note:** The exclusion of ambulance coverage "primarily for the purpose of having the patient nearer to home, family, friends or a personal physician" does not apply when the ambulance transfer is medically necessary and appropriate.

If there is documentation that the ambulance transfer is for reasons of medical necessity (e.g., the need for parental nurturing of an infant as a component of or in connection with medical treatment, the need to place a child in an appropriate level of care), then the exclusion does not apply because considerations of family/patient convenience are not the primary reason for the ambulance service.

Cost-shares for nonemergency ambulance transportation depend on the status of the patient at the time of service and may be cost-shared on an outpatient or inpatient basis.

For additional information about emergency services, refer to the *TRICARE Policy Manual*, Chapter 2, Section 6.1 at **http://manuals.tricare.osd.mil**.

## Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) refers to medical equipment or supplies that a patient needs to arrest or reduce functional loss. A physician must order DMEPOS.

Depending on which method is least expensive for TRICARE, beneficiaries may lease or purchase medically necessary DMEPOS. When receiving claims for extended rentals, TRICARE evaluates the cost benefit of purchasing the equipment.

TRICARE pays claims only up to the purchase amount. TRICARE does **not** reimburse any amount over the purchase price.

TRICARE does not send a lease/purchase agreement letter to beneficiaries for lifetime oxygen and oxygen concentrators.

A prescription requesting DMEPOS and signed by the beneficiary's physician is required for rental or purchase of DMEPOS. Prescriptions must specify the beneficiary's diagnosis, the particular type of equipment needed, the reason it is necessary and the duration for which it will be necessary.

Humana Military may accept a Certificate of Medical Necessity (CMN) in place of a prescription. Unless otherwise specified, a CMN is valid for three months.

A lifetime CMN for oxygen or oxygen equipment requires validation every 12 months. Humana Military must review equipment needed for more than one year annually to validate continued medical necessity.

When an ordering physician completes and signs the CMN, he or she is attesting that the information indicated on the form is correct and the requested services are medically necessary. Any time there is a change in the prescription, the physician must submit a new CMN.

**Note:** DMEPOS providers cannot file claims for beneficiaries under a home health episode of care. The home health provider is the only provider that can submit claims for a beneficiary under a home health episode of care. DMEPOS providers must work with the home health provider.

For information about filing DMEPOS claims, see the *Claims Processing and Billing Information* section.

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

## Home Health Care, including IV Infusion Therapy

TRICARE's home health care benefits are similar to those covered under Medicare. All home health services, including home infusion therapy, require prior authorization.

The benefit includes coverage of medical equipment, supplies, certain therapies and nursing care to homebound patients whose conditions make home visits necessary. While a beneficiary does not need to be bedridden, his or her condition should be such that there exists a normal inability to leave home and leaving home would require a considerable and taxing effort.

- Short-term absences from the home for nonmedical purposes are permitted.
- The beneficiary may attend a licensed, certified or accredited medical adult day care center.
- Absences, whether regular or infrequent, from the beneficiary's primary residence for the purpose of attending an educational program in a public or private school licensed and/or certified by a state will not negate the beneficiary's homebound status.
- Beneficiaries under age 18 and obstetrical patients need a written statement from a physician confirming that leaving home would place the beneficiary at medical risk.

Services may be delivered in whatever setting the parents and therapist deem most appropriate when provided under the Early Intervention Program (children under 3 years of age).

Humana Military may approve skilled nursing provided by a registered nurse under a physician's supervision, physical therapy from a licensed physical therapist and speech pathology from a licensed speech therapist when medically necessary. There are certification or licensure requirements for other professional disciplines providing home health services.

In the case of skilled nursing services, coverage can be extended when the following conditions are met:

- The services are ordered by, and included in, the treatment plan established by the physician.
- The services require the skills of a registered nurse under the supervision of another nurse or a physician.
- Detailed nursing notes are kept for skilled nursing services.
- Assistance with daily living activities (e.g., laundry, cleaning dishes, etc.) is not part of the home health care benefit. While home health care professionals may provide assistance with basic daily living care, this assistance is considered ancillary and not part of the professional's primary duties while in the patient's home.

An enhanced home health care option, available to qualifying beneficiaries, permits home care for up to 35 hours per week and provides some respite care for Active Duty Family Members (ADFMs) registered in ECHO.

TRICARE covers respite care for ADSMs who are homebound as a result of a serious injury or illness incurred while serving on active duty. Respite care is available if the ADSM's plan of care includes

frequent interventions by the primary caregiver.

A TRICARE-authorized home health agency must provide the respite care. It requires prior authorization from Humana Military and the ADSM's approving authority (i.e., MMSO or the referring MTF).

Infusion therapy delivered in the home may include:

- Skilled nursing services to administer the drug
- The drug and associated compounding services
- Medical supplies and Durable Medical Equipment (DME)

The TRICARE medical benefit covers the skilled nursing services, medical supplies, DME and the first five doses of the drug. After the first five doses, the therapy is considered long-term, and the drug is covered under the pharmacy benefit.

Refer to the TRICARE manuals at **http://manuals.tricare.osd.mil**:

- For information about home health care, refer to the *TRICARE Reimbursement Manual*, Chapter 12.
- For information about home health care benefits related to the TRICARE ECHO program, refer to the *TRICARE Policy Manual*, Chapter 9, Section 15.1.
- For information about ADSM respite care coverage, refer to the *TRICARE Operations Manual*, Chapter 18, Section 3 and Addendum C.
- For information about home infusion benefits, refer to the *TRICARE Policy Manual*, Chapter 8, Section 20.1.

## Individual Provider Services

TRICARE covers office visits; outpatient, office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; rehabilitation services (e.g., physical and occupational therapy, speech pathology services); and medical supplies used within the office.

Prior authorization is required for behavioral health care services after the beneficiary's initial eight visits each Fiscal Year (FY).

**Note:** Additional TRICARE Prime copays are not applied if these services are provided as part of an office visit.

## Laboratory and X-Ray Services

TRICARE generally covers laboratory and X-ray services if prescribed by a physician. However, some exceptions apply (e.g., chemo-sensitivity assays, bone density X-ray studies for routine osteoporosis screening).

The TRICARE Demonstration Project for Approved Laboratory Developed Tests (LDTs) covers two genetic tests for eligible TRICARE beneficiaries (including ADSMs): BRACAnalysis® (genetic mutation testing for breast and ovarian cancer risks) and Oncotype DX® (genetic testing for breast cancer risk). These tests require prior authorization. For more information, search for **Genetic Testing** at **Humana-Military.com**.

# Inpatient Services

## Bariatric Surgery

Bariatric surgery for morbid obesity is a covered TRICARE benefit for those who meet the criteria established by TRICARE. Bariatric surgery requires prior authorization.

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

TRICARE does not cover:

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

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

## Hospitalization

TRICARE covers hospitalization services, including general nursing; hospital, physician and surgical services; meals (including special diets); drugs and medications; operating and recovery room care; anesthesia; laboratory tests; X-rays and other radiology services; medical supplies and appliances; and blood and blood products.

TRICARE may cover semiprivate rooms and special care units if medically necessary. TRICARE may only cover surgical procedures designated as "inpatient only" when performed in an inpatient setting.

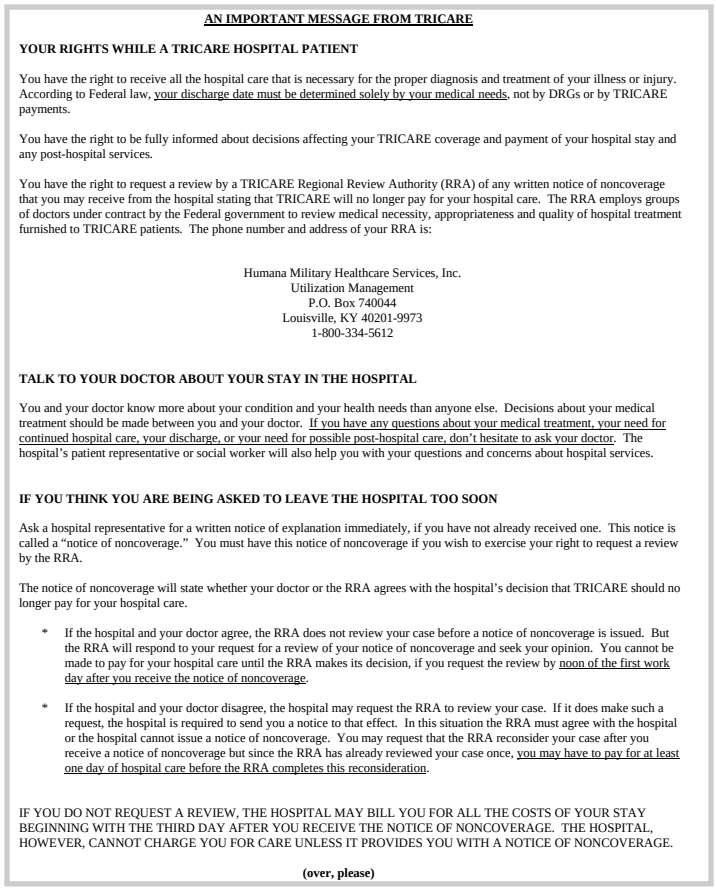
Facilities must provide beneficiaries with a copy of *An Important Message from TRICARE* at admission. To download copies of this form, search for **Important Message** at **Humana-Military.com**. Figure 5.2 on the following page shows an example of this form.

All non-urgent admissions require prior authorization. In all emergency situations, the TRICARE Prime beneficiary must notify his or her Primary Care Manager (PCM) or Humana Military of any emergency inpatient admission within 24 hours or the next business day so ongoing care can be coordinated.

The quickest, most convenient way to obtain an admission authorization is via Humana Military's secure provider portal at **Humana-Military.com**. Providers can typically obtain an authorization via the Web within 24 hours, and many times

## Important Message from TRICARE

Figure 5.2



**AN IMPORTANT MESSAGE FROM TRICARE**

**YOUR RIGHTS WHILE A TRICARE HOSPITAL PATIENT**

You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs, not by DRGs or by TRICARE payments.

You have the right to be fully informed about decisions affecting your TRICARE coverage and payment of your hospital stay and any post-hospital services.

You have the right to request a review by a TRICARE Regional Review Authority (RRA) of any written notice of noncoverage that you may receive from the hospital stating that TRICARE will no longer pay for your hospital care. The RRA employs groups of doctors under contract by the Federal government to review medical necessity, appropriateness and quality of hospital treatment furnished to TRICARE patients. The phone number and address of your RRA is:

Humana Military Healthcare Services, Inc.
Utilization Management
P.O. Box 740044
Louisville, KY 40201-9973
1-800-334-5612

**TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL**

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post-hospital care, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

**IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON**

Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "notice of noncoverage." You must have this notice of noncoverage if you wish to exercise your right to request a review by the RRA.

The notice of noncoverage will state whether your doctor or the RRA agrees with the hospital's decision that TRICARE should no longer pay for your hospital care.

* If the hospital and your doctor agree, the RRA does not review your case before a notice of noncoverage is issued. But the RRA will respond to your request for a review of your notice of noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the RRA makes its decision, if you request the review by noon of the first work day after you receive the notice of noncoverage.

* If the hospital and your doctor disagree, the hospital may request the RRA to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation the RRA must agree with the hospital or the hospital cannot issue a notice of noncoverage. You may request that the RRA reconsider your case after you receive a notice of noncoverage but since the RRA has already reviewed your case once, you may have to pay for at least one day of hospital care before the RRA completes this reconsideration.

IF YOU DO NOT REQUEST A REVIEW, THE HOSPITAL MAY BILL YOU FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE NOTICE OF NONCOVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDES YOU WITH A NOTICE OF NONCOVERAGE.

**(over, please)**

approval is immediate. Providers may also fax the request to Humana Military at **1-877-548-1547**.

## Skilled Nursing Facility (SNF) Care

All admissions or transfers to an SNF require prior authorization. Skilled nursing care is provided at an SNF rather than in a nursing home or a patient's home.

TRICARE only covers care at Medicare-certified, TRICARE-participating SNFs in semiprivate rooms. Using a network facility decreases the cost to the beneficiary.

TRICARE covers skilled nursing services; meals (including special diets); physical, occupational and speech therapy; drugs furnished by the facility; and necessary medical supplies, equipment and appliances. Custodial care is not covered.

TRICARE only covers SNF admissions for patients with qualifying medical conditions treated in hospitals for at least three consecutive days (not including the day of discharge). SNF admission may be covered as long as the patient is admitted within 30 days of his or her discharge from the hospital (with some exceptions for medical reasons).

For more information about SNF care, refer to the *TRICARE Policy Manual*, Chapter 2, Section 4.1, and the *TRICARE Reimbursement Manual*, Chapter 8 at **http://manuals.tricare.osd.mil**.

## Maternity Care

Maternity care includes medical services related to prenatal care, labor and delivery, and postpartum care.

**Note**: TRICARE covers maternity care for a TRICARE-eligible dependent daughter of an ADSM or retired service member. However, TRICARE does **not** cover care for the newborn grandchild unless the newborn is otherwise eligible as an adopted child or the child of another eligible sponsor.

The PCM for a beneficiary who becomes pregnant must submit a referral request prior to the mother's first pregnancy-related appointment with an obstetrician. The referral begins with the first prenatal visit and remains valid until 42 days after birth.

Prior to the delivery, the PCM must obtain a prior authorization for the civilian (non-MTF) inpatient facility or birthing center where the beneficiary plans to deliver. The inpatient length of stay cannot be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section.

Notify Humana Military if the mother is hospitalized or placed in observation during the pregnancy for any reason other than delivery.

If a newborn remains in the hospital after the mother is discharged, a separate inpatient authorization is required for the newborn. A newborn is covered as a TRICARE Prime or TPR beneficiary for the first 60 days following birth or adoption as long as one additional family member is enrolled in TRICARE Prime or TPR. If the child is not enrolled in TRICARE Prime or TPR within 60 days, coverage will revert to the TRICARE Standard program option.

Covered services include:

- Obstetric visits throughout the pregnancy
- Medically necessary fetal ultrasounds
- Hospitalization for labor, delivery and postpartum care
- Anesthesia for pain management during labor and delivery
- Medically necessary cesarean sections
- Management of high-risk or complicated pregnancies

The following services are **not** covered:

- Fetal ultrasounds that are not medically necessary (e.g., to determine the baby's sex), including three- and four-dimensional ultrasounds
- Services and supplies related to non-coital reproductive procedures (e.g., artificial insemination)
- Management of uterine contractions with drugs that are not U.S. Food and Drug Administration-approved for that use (i.e., off-label use)
- Home uterine-activity monitoring and related services
- Unproven procedures (e.g., lymphocyte or paternal leukocyte immunotherapy to treat recurring miscarriages, salivary estriol test for preterm labor)

- Umbilical cord blood collection and storage, except for patients who undergo umbilical stem cell transplantation for a covered transplant
- Private hospital rooms
- Postpartum inpatient stay for a mother to remain with a newborn infant (usually primarily for the purpose of breastfeeding the infant) when the infant (but not the mother) requires the extended stay
- 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

### Maternity Ultrasounds

TRICARE covers professional and technical components of medically necessary fetal ultrasounds as well as the maternity global fee. TRICARE covers medically necessary maternity ultrasounds that may be needed 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.
- Evaluate the fetus's condition in late registrants for prenatal care.

**Note:** TRICARE does **not** cover ultrasounds for routine screening or to determine the sex of the baby.

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

## Hospice Care

The TRICARE hospice benefit is designed to provide **palliative** care to individuals with a prognosis of less than six months to live if the terminal illness runs its normal course. TRICARE has adopted most of the provisions currently set out in Medicare's hospice coverage benefit guidelines, reimbursement methodologies and certification criteria for participation in the hospice program.

In order for the beneficiary to change his or her status from the TRICARE basic program to the hospice program:

- The beneficiary must elect to receive hospice care for each specific period of time unless there has been no interruption of the hospice care election.
- An election form must be signed with each change in status. Election forms are provided by the hospice program.
- The initial election period into hospice care requires written certification from the attending physician and hospice medical director stating the beneficiary has a life expectancy of six months or less.
- For subsequent election periods, the only requirement is certification by the attending physician or the medical director of the hospice program. (Electronic signature is acceptable.)

There are four levels of care within the hospice benefit:

- Continuous home care
- General hospice inpatient care
- Inpatient respite care
- Routine home care

Care within the four levels may include physician services, nursing care, counseling, medical equipment, supplies, medications, medical social services, physical and occupational services, speech and language pathology, and hospice short-term acute patient care related to the terminal illness.

Because hospice care emphasizes supportive services, such as pain control and home care, the benefit allows for home health aid and personal comfort items, which are limited under TRICARE's main coverage programs. However, services for an unrelated condition or injury, such as a broken bone or unrelated diabetes, are still covered as a regular TRICARE benefit.

TRICARE does **not** cover room and board unless the patient is receiving inpatient or respite care. Patients cannot receive other TRICARE services or benefits (e.g., curative treatments related to the terminal illness) unless the hospice care is formally revoked. No care for the illness is covered by TRICARE unless the hospice program provides or arranges for the care.

To formally revoke the hospice election, the beneficiary must submit a signed, dated statement through the hospice provider. If the beneficiary chooses to revoke hospice, any remaining days in that period are forfeited, but hospice coverage for any election period may be elected at any time.

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

## Limitations and Exclusions (Medical/Surgical)

To determine if a specific service is a covered benefit or if coverage is limited**,** check the current list of noncovered services on the No Government Pay Procedure Code List at **www.TRICARE.mil/NoGovernmentPay**.

The following is a list of medical/surgical services that are generally not covered under TRICARE or are covered with significant limitations. **This list is not all-inclusive.**

See the *Behavioral Health Care Services* section for a list of behavioral health care limitations and exclusions.

## Limitations

**Abortions:** Abortions are only covered when the life of the mother would be endangered if the pregnancy were carried to term. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided.

**Botulinum toxin injections:** TRICARE may cost-share botulinum toxin type A injections, also known as Botox®, for the treatment of the following:

- Cervical dystonia (repetitive contraction of the neck muscles) for patients 16 years of age and older
- Blepharospasm (spasm of the eyelids/uncontrolled blinking) for patients 12 years of age and older
- Severe underarm sweating that cannot be managed by topical agents for patients 18 years of age and older
- Chronic anal fissure that does not respond to conservative therapies
- Spasticity resulting from cerebral palsy
- Sialorrhea associated with Parkinson's disease patients who are refractory to, or unable to tolerate, systemic anticholinergics
- Prophylaxis of migraine headaches in adult patients who have migraines 15 days or more per month with headaches lasting four hours a day or longer
- Tightness in flexor muscles of the elbow, wrist and fingers (upper limb spasticity) in adults
- Laryngeal dystonia (spasmodic dysphonia)
- Oromandibular dystonia (jaw-closing dystonia)

TRICARE may cost-share botulinum toxin type B, also known as MYOBLOC, for the treatment of sialorrhea associated with Parkinson's disease. TRICARE may cost-share botulinum toxin B, also known as RimabotulinumtoxinB, for the treatment of cervical dystonia in patients 16 years and older.

TRICARE does not cover Botox injections for the following:

- Cosmetic procedures
- Lower back pain
- Severe hand sweating
- Chronic daily headaches, cluster headaches, cervicogenic headache or tensions-type headaches
- Urinary incontinence
- Muscle spasms caused by cervical degenerative disc disease or spinal column stenosis

**Breast pumps:** Heavy-duty, hospital-grade (E0604) electric breast pumps (including services and supplies related to the use of the pump) for mothers of premature infants are covered. An electric breast pump is covered while the premature infant remains hospitalized during the immediate postpartum period.

Hospital-grade electric breast pumps may also be covered after the premature infant is discharged from the hospital for a physician-documented medical reason. This documentation is also required for premature infants delivered in nonhospital settings.

Breast pumps of any type, when used for reasons of personal convenience, are excluded even if prescribed by a physician. Manual breast pumps (E0602) and basic (non-hospital grade) electric pumps (E0603) are also excluded.

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

**Chiropractic care:** Coverage is limited to ADSMs and is only available at specific MTFs under the Chiropractic Care Program.

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

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

**Diagnostic genetic testing:** TRICARE only covers medically proven and appropriate diagnostic genetic testing if the results will influence a patient's medical management. Bill services using the appropriate Evaluation and Management codes. Refer to the *TRICARE Policy Manual*, Chapter 6, Section 3.1 at **http://manuals.tricare.osd.mil**. For antepartum services, refer to the *TRICARE Policy Manual*, Chapter 4, Section 18.2.

**Education and training:** Education and training are only covered under the TRICARE ECHO and diabetic outpatient self-management training services. Diabetic outpatient self-management training services must be performed by programs approved by the American Diabetes Association®. The provider's Certificate of Recognition from the American Diabetes Association must accompany the claim for reimbursement.

**Eyeglasses and contact lenses:** ADSMs may receive eyeglasses at MTFs at no cost. For all other beneficiaries, the following are covered,

but prior authorization from Humana Military is required:

- Contact lenses and/or eyeglasses for treatment of 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
- Intraocular lenses, contact lenses or eyeglasses for loss of human lens function resulting from interocular surgery, ocular injury or congenital absence

Adjustments, cleaning and repairs for eyeglasses are not covered.

**Facility charges for non-adjunctive dental services:** Hospital and anesthesia charges related to routine dental care for children under age 5 or those with disabilities may be covered in addition to dental care related to certain medical conditions.

**Food, food substitutes and supplements, and other nutritional supplements:** Food, food substitutes and supplements, and other nutritional supplements are covered when medically justified as the primary source of nutrition (e.g., enteral or parenteral nutrition therapy).

**Hearing aids:** Hearing aids and certain repairs are covered only for ADFMs who meet specific hearing-loss requirements.

**Laser/LASIK/refractive corneal surgery:** Surgery is covered only to relieve astigmatism following a corneal transplant.

**Private hospital rooms:** Private rooms are not covered unless ordered for medical reasons or because a semiprivate room is not available. Hospitals that are subject to the TRICARE Diagnosis-Related Group (DRG) payment system may provide the patient with a private room but will receive only the standard DRG amount. The hospital may bill the patient for the extra charges if the patient requests a private room.

**Shoes, shoe inserts, shoe modifications and arch supports:** Shoes and shoe inserts are covered only in limited circumstances. Orthopedic shoes may be covered if they are a permanent part of a brace. For individuals with diabetes, extra-depth shoes with inserts or custom-molded shoes with inserts may be covered.

**Vitamins:** Cost-sharing may apply for legend vitamins specifically used to treat medical conditions. In addition, prescription prenatal vitamins for prenatal care may be cost-shared.

## Exclusions

In general, TRICARE excludes services and supplies not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including behavioral 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 noncovered condition or treatment, or provided by an unauthorized provider, are excluded.

**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 noncovered services by signing the *TRICARE Noncovered Services Waiver* form. For more information, see *Informing Beneficiaries about Noncovered Services* in the *Important Provider Information* section.

The following specific services are excluded under all circumstances. **This list is not all-inclusive.**

- Acupuncture (It may be offered at some MTFs and approved for certain ADSMs, but it is not covered for care performed by civilian providers.)
- Alterations to living spaces
- Artificial insemination, including in vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies
- Autopsy services or postmortem examinations
- Birth control/contraceptives (non-prescription)
- Camps (e.g., for weight loss)
- Charges that providers may apply to missed or rescheduled appointments
- Counseling services not medically necessary for the treatment of a diagnosed medical condition (e.g., educational, vocational and socioeconomic counseling; stress management; lifestyle modification)
- Custodial care
- Diagnostic admission
- Domiciliary care
- Dyslexia treatment
- Electrolysis
- Elevators or chairlifts
- Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club memberships or other such charges or items
- Experimental or unproven procedures (unless authorized under specific exceptions in the TRICARE regulations)
- Foot care (routine), except if required as a result of a diagnosed, systemic medical disease affecting the lower limbs, such as severe diabetes
- General exercise programs, even if recommended by a physician and regardless of whether rendered by an authorized provider

- 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 have been and are performed routinely on an outpatient basis
    - In hospitals or other authorized institutions above the appropriate level required to provide necessary medical care
- Learning disability services
- Medications:
    - Drugs prescribed for cosmetic purposes
    - Fluoride preparations
    - Homeopathic and herbal preparations
    - Multivitamins
    - Over-the-counter products (except insulin and diabetic supplies)
    - Weight-reduction products
    - Megavitamins and orthomolecular psychiatric therapy
- Mind expansion and elective psychotherapy
- Naturopaths
- Nonsurgical treatment of obesity or morbid obesity
- Personal, comfort or convenience items, such as beauty and barber services, radio, television and telephone
- Preventive care, such as routine, annual or employment-requested physical examinations; routine screening procedures; or immunizations, except as provided under the Clinical Preventive Services benefit (See *Clinical Preventive Services* earlier in this section.)
- Psychiatric treatment for sexual dysfunction
- Services and supplies:
    - Provided under a scientific or medical study, grant or research program
    - Furnished or prescribed by an immediate family member
    - 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 (i.e., 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 *Bariatric Surgery* earlier in this section.)
    - Inpatient stays directed or agreed to by a court or other governmental agency (unless medically necessary)
    - Required as a result of 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
    - That are (or are eligible to be) fully payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (In such instances, TRICARE is the secondary payer for any remaining charges.)
- Sex changes or sexual inadequacy treatment, with the exception of treatment of ambiguous genitalia that has been documented to be present at birth
- Sterilization reversal surgery
- Surgery performed primarily for psychological reasons (such as psychogenic surgery)
- Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE
- Transportation, except by ambulance
- X-ray, laboratory and pathological services and machine diagnostic tests not related to a specific illness, injury or a definitive set of symptoms, except for cancer screening and other tests allowed under the Clinical Preventive Services benefit

# Health Care Management and Administration



## Referrals and Authorizations

When a Primary Care Manager (PCM) is unable to provide a specialized medical service, the PCM must contact Humana Military to request a referral. Humana Military authorizes the referral to a network civilian professional or ancillary provider **only if the requested services are not available at the Military Treatment Facility (MTF) or the PCM's office**.

### MTF Right Of First Refusal

The MTF is always the primary source of specialty care for TRICARE Prime beneficiaries, and it has the Right Of First Refusal (ROFR) for TRICARE Prime referrals within their catchment area for all specialty care, specialty appointments and procedures requiring prior authorization, provided the MTF is able to deliver the service requested by the patient's civilian provider.

This means TRICARE Prime enrollees must first try to obtain care at MTFs. MTF staff members review referrals to determine if they can provide care within access standards. If the service is not available within access standards, the MTF refers the beneficiary to a TRICARE network provider.

**Note:** ROFR does not apply to TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM).

### Submitting Referral and Authorization Requests

Providers may submit referral and authorization requests using the secure Self-Services for Providers portal at **Humana-Military.com**. To get started, log in to Self-Service for Providers and click New Request to submit a new referral or authorization, including hospitalization.

Providers can complete the request in five steps:

1. Enter patient and service information.
2. Select the procedures to perform.
3. Review existing authorizations to determine if services have already been approved.
4. Select the provider.
5. Enter the clinical information.

Providers can typically obtain a referral or authorization via the Web within 24 hours, and many times approval is immediate. Providers may also review existing referrals and authorizations to determine their status and add visits or services.

When submitting a new referral or authorization, it is important to maintain the integrity of the data by preventing and checking for duplicate entries. Entering duplicate requests may cause confusion related to the status of the referral or authorization, and it can slow down referral processing time and delay claims payment.

If a current, valid referral or authorization exists for the same type of service and setting, the system will highlight it in red. If the new request is a duplicate, go to the Update screen of the existing one to update providers, enter dates of service and add procedures.

If a provider has no Web access, he or she may fax the *Patient Referral Authorization Form* (PRAF) to Humana Military at **1-877-548-1547**.

For urgent referrals, call **1-800-444-5445**.

### Specialist-to-Specialist Referrals for the Same Episode of Care

Some referrals may be authorized from one specialty care provider to another, bypassing the need for another PCM referral.

- Specialists may refer to the same specialty or subspecialty in the same type of service.
- Specialists may refer to ancillary services (e.g., physical therapy, occupational therapy, speech therapy, Durable Medical Equipment [DME], home health, etc.).
- Specialists may refer for pre-procedure surgical clearance from another specialty (e.g., cardiology, pulmonary, hematology, gastroenterology, etc.) directly.

Specialist-to-specialist referrals:

- Apply only when a valid Evaluate and Treat referral from the PCM was previously authorized for the same episode of care.
- Are not allowed for Active Duty Service Members (ADSMs).
- Will not be authorized if the patient needs services beyond the PCM referral's original scope. The PCM must approve additional services.

### Autofax Confirmation

The PCM and the referred-to provider will receive an automatic fax when care is authorized. Figure 6.1 on the following page shows an example of this confirmation.

## Autofax Confirmation Figure 6.1

**IMPORTANT**
Return Discharge Summary or Operative Report/Consultation to the referring clinician fax # listed below.

Include this form as a coversheet for your fax.

FAX: (xxx) xxx-xxxxx AUTH/ORDER # xxxxxxxxxxxxx

DATE:

DR. JOHN SMITH
123 MAIN STREET PHONE: (xxx) xxx-xxxx
JACKSONVILLE, FL 12345 FAX#: (xxx) xxx-xxxx

**HUMANA MILITARY --- TRICARE REFERRAL/AUTHORIZATION**

You've been approved to provide the services described below. If an appointment is required to provide these services, the beneficiary will contact you. Please schedule the appointment within the TRICARE access standard. Wait time for specialty care appointments is based on the nature of the care required, but should not exceed four weeks. Units shown below are the **total** number of visits or procedures covered by this authorization number**.** Routine ancillary lab, skin biopsy, and radiology diagnostic tests do not require specific authorization. This authorization does not guarantee payment. Payment is based on TRICARE eligibility and compliance with TRICARE policy. If further information about this authorization is required, please contact Humana Military at (800)444-5445).**Inpatient care requires notification by the hospital and separate authorization.**

BENEFICIARY INFORMATION: HELEN SMITH SPONSOR ID: last 4 digits
PHONE: (xxx) xxx-xxxx

FACILITY:

| AUTHORIZED SERVICES: | UNITS: | BETWEEN DATES: |
|---|---|---|
| OFFICE CONSULT NEW OR EXTABLISHED PT | 1 | xx/xx/xxxx – xx/xx/xxxx |
| OFFICE OR OP VISIT ESTABLISHED PATIENT | 1 | xx/xx/xxxx – xx/xx/xxxx |

[FAX NOTES]

REASON FOR REFERRAL:

To improve coordination of care, TRICARE requires a report of this referral to be provided to the Primary Care Manager (PCM)/referring provider within 10 days of the visit. The fax number is listed below.

REFERRING CLINICIAN: Name and Address PHONE: (xxx) xxx-xxxx **FAX #:** (xxx) xxx-xxxx
ORDERING PROVIDER:

Log on to *MyHMHS* at **www.humana-military.com.** Enter the auth/order number listed above and this key code for immediate access: **XXXX**

- Eligibility, referral status and prescription history for the patient
- Submit requests for new referrals and authorizations, often with immediate approval

This transmittal is intended only for the use of the individual or entity to which it is addressed and contains Protected Health Information, which is CONFIDENTIAL. This information may only be used or disclosed in accordance with federal law, which contains penalties for misuse. If you are not the intended recipient of this transmission, you may not otherwise use or disclose the information contained in this transmission. If you receive this transmission in error, please return the transmission to Humana Military at 1-888-385-4565 and delete or destroy this information. Thank you.

Authorization is based on whether the referral is for a covered service. The automatic fax will specify the services authorized, the number of visits and the timeframe in which the visits must occur. The beneficiary will also receive a letter notifying him or her of the approved referral or authorization.

Providers should program their office/referral fax number into their fax machine to ensure the number appears on their referral requests.

## Emergency Care

Under all TRICARE programs, no referrals or authorizations are required for TRICARE beneficiaries receiving emergency care inside or outside of their TRICARE regions. However, TRICARE Prime beneficiaries must contact their PCMs or Humana Military within 24 hours of an inpatient admission, or the next business day, to coordinate ongoing care.

Emergency care is covered for medical, maternity or psychiatric conditions that would lead a prudent layperson (someone with average knowledge of health and medicine) to believe that a serious medical condition exists or that the absence of immediate medical attention would result in a threat to life, limb or sight, or when the person manifests painful symptoms requiring immediate palliative effort to relieve suffering. This includes situations where a beneficiary arrives at the emergency room with severe pain (except dental pain) or is at immediate risk of serious harm to self or others.

In the case of a pregnant woman, the danger to the health of the woman or her unborn child must be considered. In the absence of other qualifying conditions, pain associated with pregnancy or incipient birth after the 34th week of gestation when associated with a pregnancy is not an emergency condition for adjudication purposes.

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

## Urgent Care

TRICARE Prime beneficiaries must obtain referrals from their PCMs or Humana Military for urgent care. If a TRICARE Prime beneficiary does not receive a referral, the claim will be paid under the Point-Of-Service (POS) option.

If providing emergency or urgent care services to a TRICARE beneficiary from a different region, the beneficiary will be responsible for paying the applicable cost-share, and providers must submit reports and claims information to the region in which the TRICARE beneficiary resides, **not** the region in which he or she received care.

For more information, see *TRICARE Regions* in the *Welcome to TRICARE and the South Region* section. For information about submitting out-of-region claims, see *Processing Claims for Out-of-Region Care* in the *Claims Processing and Billing Information* section.

## Routine Care

TRICARE beneficiaries are instructed to receive all routine care, when possible, from network providers in their designated regions. However, in some cases, beneficiaries will receive routine care in another region. In such cases, the following guidelines apply:

- TRICARE Standard beneficiaries will pay applicable cost-shares, and providers will submit claims to the regions where beneficiaries reside, **not** the region in which they received care.
- TRICARE Prime beneficiaries will receive referrals 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 beneficiaries reside, **not** the region in which they received care. If a TRICARE Prime beneficiary does not receive a referral for out-of-region care, claims will be paid under the POS option.
- The POS option does not apply to ADSMs, children for the first 60 days following birth or adoption, the first eight outpatient behavioral health care visits to a network provider per Fiscal Year (October 1 to September 30), emergency care or beneficiaries with Other Health Insurance (OHI).

## Discharge Planning

Discharge planning helps decrease or eliminate barriers that may disrupt a timely discharge from the acute care setting. Discharge planning begins on admission review and continues throughout the

hospital stay. Activities include arranging for services such as home health and DME needed after discharge and coordinating transfers to lower levels of care to minimize inappropriate use of hospital resources.

To help facilitate beneficiary reintegration following inpatient services and prevent hospital readmissions, Humana Military nurses conduct post-discharge calls to beneficiaries with traumatic injuries, burns, high-risk obstetrics, back surgery, hip and knee replacements, and prolonged hospitalization of more than 20 days.

During these calls, nurses explore (or confirm) family support and assistance at home, DME needs, depression propensity, and understanding of medication and transportation issues, and they encourage compliance with discharge instructions. Humana Military nurses also educate the beneficiary on recognizing complications, managing symptoms, monitoring recovery and ensuring follow-up care as needed.

# TRICARE Quality Monitoring Contractor

KePRO is the TRICARE Quality Monitoring Contractor (TQMC) and assists DoD Health Affairs, TRICARE Management Activity (TMA), MTF market managers and the TRICARE Regional Offices by providing the government with an independent, impartial evaluation of the care provided to beneficiaries within the Military Health System (MHS). The TQMC reviews care provided by TRICARE network providers and subcontractors on a limited basis. The TQMC is part of TRICARE's Quality and Utilization Peer Review Organization Program, in accordance with 32 Code of Federal Regulations (CFR) 199.15.

To facilitate TQMC reviews, providers' medical records may be requested by Humana Military on a monthly basis to comply with requirements detailed in the *TRICARE Operations Manual*, Chapter 7, Section 3 at **http://manuals.tricare.osd.mil**. Providers may be required to submit records to Humana Military to comply with requests for medical records submitted by KePRO to Humana Military.

Providers that receive requests for medical records are required to submit the requested medical record in its entirety to Humana Military. Failure to do so will result in recoupment of payment for the hospitalization and/or any other services in accordance with 32 CFR 199.4(a)(5).

# Medical Records Documentation

Humana Military may review a provider's medical records on a random basis to evaluate patterns of care and compliance with performance standards. Policies and procedures should be in place to help ensure that a beneficiary's medical record is kept organized and confidential. 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.

# Peer Review Organization Agreement

Humana Military has review authority over health care services provided in civilian facilities to MHS beneficiaries in the TRICARE South Region.

To participate in the care of TRICARE beneficiaries, facilities must establish a Peer Review Organization (PRO) Agreement with Humana Military in accordance with 32 CFR 199.15(g). For more information, refer to the *TRICARE Operations Manual*, Chapter 7, Section 1 at **http://manuals.tricare.osd.mil**.

The PRO Agreement is separate from a network contract, and network and non-network facilities are required to sign one. The agreement is a signed acknowledgement that Humana Military is the PRO for the TRICARE South Region.

If a corporation has multiple facilities, one signed agreement may cover all the facilities. Please attach a list that includes each facility and its respective tax ID.

The PRO Agreement confirms that the facility will cooperate with Humana Military and its subcontractors by:

- Providing copies of medical records
- Providing accurate information on patients' conditions
- Informing patients of their rights and responsibilities
- Providing other assistance that may be required for Humana Military to conduct comprehensive utilization and quality management programs for care of MHS beneficiaries who are patients of the facility

The PRO Agreement is also an acknowledgement that the facility understands the utilization and quality review processes and that potential financial penalties may be incurred by failing to obtain preauthorization when required.

# Utilization Management

## Prior Authorizations and Prospective Reviews

Certain requested services, procedures or admissions require prior authorization. **Prospective review** (preauthorization) is the process by which specified services are reviewed for medical necessity prior to the services being provided. The primary focus of prospective review is to ensure services requested are medically necessary and provided in the appropriate setting.

**Prior authorizations** are based on medical necessity and are not a guarantee of payment. When a TRICARE provider fails to obtain prior authorization, or exceeds the scope of an approved referral/authorization, he or she may incur penalties.

First-level reviewers may issue denial determinations based on coverage limitations contained in 32 CFR 199, the *TRICARE Policy Manual* and other TRICARE guidance (these are considered factual determinations) or refer the case to second-level review. Physicians who did not participate in the first-level review of the care under consideration conduct second-level reviews. Figure 6.2 on the following page lists procedures and services that require prior authorization from Humana Military.

## Prior Authorization List for the South Region — Figure 6.2

| Procedures and Services |
|---|
| • Adjunctive dental care |
| • Advanced life support air ambulance in conjunction with stem cell transplantation |
| • Bariatric surgery |
| • Department of Defense (DoD) In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial |
| • Educational interventions under the DoD Enhanced Access to Autism Services Demonstration |
| • Extended Care Health Option (ECHO) services |
| • Home health services, including home infusion |
| • Hospice |
| • Lab Developed Tests (LDTs) Demonstration Project |
| • Phase II and Phase III cancer clinical trials |
| • Transplants (solid organ and stem cell, not corneal transplant) |
| **Inpatient Hospital Stays** |
| • Acute care admissions (Notification of acute care admission is required by the next working day.) |
| • Admissions or transfers to Skilled Nursing Facilities (SNFs), rehabilitation and Long-Term Acute Care (LTAC) |
| • Discharge notification |
| **Behavioral Health** |
| • Nonemergency admissions to inpatient hospitals for psychiatric and substance use disorders |
| • Partial Hospitalization Programs (PHPs) for psychiatric and substance use disorders |
| • Residential Treatment Centers (RTCs) |
| • Outpatient behavioral health care visits exceeding the initial eight visits each Fiscal Year (October 1 to September 30) |
| • Psychoanalysis |

*The information contained in this figure is not all-inclusive. The list of services requiring prior authorization changes periodically. For the most current list, go to* ***Humana-Military.com****.*

ADSMs require prior authorization (except for emergencies) for all inpatient and outpatient services from civilian network or non-network providers. This ensures that ADSMs continue to meet fitness-for-duty requirements as a result of outpatient visits such as pregnancy (maternity) care, physical therapy, behavioral health care services and family counseling.

### Concurrent Review

Concurrent review is the review of continued inpatient stay to determine medical necessity, quality of care and appropriateness of the level of care being provided. Concurrent review ensures appropriate, efficient and effective utilization of medical resources.

When approving inpatient admissions, an approved number of days are assigned, and the last covered date is set. If facility does not request an extension, there is no further review. If the patient remains hospitalized beyond the approved number of days, a provider penalty will be applied to the additional days.

### Retrospective Review

Retrospective review is conducted when a certain procedure or service requires a medical necessity review but was not previously authorized.

## Clinical Quality Management

The Humana Military Quality Management Department is responsible for oversight of clinical care provided to TRICARE beneficiaries. TRICARE providers must agree to participate in clinical quality studies and to make their medical records available for review for quality purposes. TRICARE Prime beneficiaries and PCMs receive reminder letters from the Humana Military Quality Management Department to promote awareness of recommended preventive care services.

## Case Management

Humana Military nurses provide case management services for

TRICARE beneficiaries with complex health needs. The following conditions warrant mandatory referral to case management:

- Transplant evaluation or procedure (solid organ or bone marrow/peripheral stem cell)
- Ventilator dependence
- Acute inpatient rehabilitation (not skilled facility with therapy only)
- Traumatic brain injury, spinal cord injury, stroke, new blindness
- New quadriplegia or paraplegia
- Premature infant: ventilator-dependent more than 24 hours and/or weight less than 1,500 grams
- Planned Long-Term Acute Care (LTAC) admission
- Catastrophic illness or injury, amputation, multiple trauma
- Pregnancy with significant identified risks
- Hourly nursing care more than four hours per day
- Burn injury requiring a burn unit
- Unplanned admissions to acute hospital three times or more within 90 days with the same diagnosis
- Chronic condition resulting in high resource consumption (e.g., hemophilia, Gaucher's disease)
- ECHO requests
- Transfer to an MTF or network facility

This list is **not** all-inclusive and is subject to change. Beneficiaries with a complex case who may benefit from case management are eligible for an evaluation, and providers should refer them to Humana Military.

# Humana Military Disease Management Program

The Humana Military Disease Management Program assists beneficiaries in the TRICARE South Region who are not age 65 or older and not eligible for Medicare. The program's goal is to improve each participant's symptoms, functional abilities and overall quality of life by closely monitoring the patient's treatment program and regular activities.

TRICARE Management Activity (TMA) identifies beneficiaries at specific stages of certain diseases, and registered nurses contact potential participants. The nurses work with the beneficiaries and their physicians to identify problems, establish goals and monitor progress through regular follow-up care.

As needed, patients can contact their assigned nurses to review treatment plans and ask questions. The Humana Military Disease Management Program is offered to those beneficiaries identified by TMA for heart failure, asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes, major depression and anxiety disorders.

For more information, search for **Disease Management** at **Humana-Military.com**.

# Appealing a Decision

TRICARE beneficiaries have the right to appeal decisions made by TMA or Humana Military. The appeals process varies, depending on whether the denial of benefits involves medical necessity determination, factual determination, provider authorization or a provider sanction.

All initial and appeal denials explain how, where and by when to file the next level of appeal. An appeal cannot challenge the propriety, equity or legality of any provision of law or regulation.

## Proper Appealing Parties

- A TRICARE beneficiary (including minors)
- A non-network participating provider
- A provider who has been denied approval as a TRICARE-authorized provider or who has been terminated, excluded, suspended or otherwise sanctioned
- A person who has been appointed in writing by the beneficiary to represent him or her in the appeal
- An attorney filing on behalf of a beneficiary
- A custodial parent or guardian of a beneficiary under 18 years of age

A network provider is never an appropriate appealing party unless the beneficiary has appointed the provider, in writing, to represent him or her for the purpose of the appeal. To avoid a possible conflict of interest, an officer or employee of the U.S. government — such as an employee or member of a uniformed service, including an employee or staff member of a uniformed services legal office, or a Beneficiary Counseling and Assistance Coordinator, subject to exceptions in Title 18, U.S. Code, Section 205 — is not eligible to serve as a representative unless the beneficiary is an immediate family member.

## Medical Necessity Determinations

Medical necessity determinations are based on whether, from a medical point of view, the suggested care is appropriate, reasonable and adequate for the beneficiary's condition. Providers should note the following:

- Determinations relating to health benefits are considered medical necessity determinations.
- Expedited procedures exist for appealing decisions denying requests for prior authorizations and continued inpatient stays.
- If an expedited appeal is available, the initial and appeal denial decisions will fully explain how to file an expedited appeal.

## Factual Determinations

Factual determinations involve issues other than medical necessity. Some examples of factual determinations include coverage issues (i.e., determining whether the service is covered under TRICARE policy or regulation), all foreign claims determinations and denial of a provider's request for approval as a TRICARE-authorized provider.

## Provider-Sanction Determinations

Providers who request approval as a TRICARE-authorized provider but are denied approval by either TMA or Humana Military may appeal those decisions and request a reconsideration. Provider-sanction determinations occur when providers are expelled from TRICARE.

Providers may be sanctioned by TRICARE because of failure to maintain credentials, fraud, abuse, conflict of interest or other reasons. Only the provider or his or her representative can appeal a sanction. In the event of an appeal, an independent hearing officer will conduct a hearing administered by the TMA Appeals and Hearings Division.

Providers who are not eligible for TRICARE authorization because of fraud and abuse against another federal or federally funded program or a state or local licensing authority (e.g., Medicare or Medicaid) may not appeal through the TRICARE system.

## Nonappealable Issues

Certain issues are considered nonappealable. Nonappealable issues include the following:

- POS determinations, with the exception of whether services were related to an emergency and are, therefore, exempt from the requirement for referral and authorization
- Allowable charges (The TRICARE allowable charge for services or supplies is established by regulation.)
- A beneficiary's eligibility (This determination is the responsibility of the uniformed services.)
- Provider sanction (The provider is limited to exhausting administrative appeal rights.)
- Network provider/contractor disputes
- Denial of services from an unauthorized provider
- Denial of a treatment plan when an alternative treatment plan is selected
- Denial of services by a PCM

Send prior authorization appeals to Humana Military:

Humana Military
Attn: Utilization Management
P.O. Box 740044
Louisville, KY 40201-9973

Send behavioral health appeals to:

ValueOptions Behavioral Health
Attn: Appeals and Reconsideration Department
P.O. Box 551138
Jacksonville, FL 32255-1138

# Waiver of Liability

Subject to application of other TRICARE definitions and criteria, the principle of waiver of liability is summarized as follows:

If the beneficiary did not know, or could not reasonably be expected to know, that certain services were potentially excludable from the basic TRICARE program by virtue of not being medically necessary, not provided at an appropriate level, custodial care or other reason relative to reasonableness, necessity or appropriateness, then the beneficiary will not be held liable for such services and, under certain circumstances, payment may be made for the excludable services as if the exclusion for such services did not apply.

The TRICARE beneficiary can be held financially responsible in the following instances:

- If both the **non-network** participating provider and the beneficiary knew the services were excluded
- If the beneficiary did not notify the **non-network** participating provider of having TRICARE coverage
- If the beneficiary knew the services were excluded, but the **non-network** participating provider did not

Waiver of liability **does not** apply to services provided by a network provider. Network providers may **never** bill beneficiaries for services denied for medical necessity or appropriateness. This requirement does not apply to TRICARE network pharmacies.

# Fraud and Abuse

Program integrity is a comprehensive approach to detecting and preventing fraud and abuse. Prevention and detection are results of functions of the prepayment control system, the postpayment evaluation system, quality assurance activities, reports from beneficiaries and identification by a provider's employees or Humana Military staff.

TMA oversees the fraud and abuse program for TRICARE. The Program Integrity Branch analyzes and reviews cases of potential fraud (i.e., the intent to deceive or misrepresent to secure unlawful gain).

Some examples of fraud include:

- Billing for services, supplies or equipment not furnished or used by the beneficiary
- Billing for costs of noncovered or nonchargeable services, supplies or equipment disguised as covered items
- Violating the participation agreement, resulting in the

beneficiary being billed for amounts that exceed the TRICARE allowable charge or cost

- Duplicate billings (e.g., billing more than once for the same service, billing TRICARE and the beneficiary for the same services, submitting claims to both TRICARE and other third parties without making full disclosure of relevant facts or immediate full refunds in the case of overpayment by TRICARE)
- Misrepresentations of dates, frequency, duration or description of services rendered or misrepresentations of the identity of the recipient of the service or who provided the service
- Reciprocal billing (i.e., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed)
- Practicing with an expired, revoked or restricted license (An expired or revoked license in any state or U.S. territory will result in a loss of authorized-provider status under TRICARE.)
- Agreements or arrangements between the provider and the beneficiary that result in billings or claims for unnecessary costs or charges to TRICARE

The Program Integrity Branch also reviews cases of potential abuse (i.e., practices inconsistent with sound fiscal, business or medical procedures and services not considered to be reasonable and necessary). Such cases often result in inappropriate claims for TRICARE payment.

Some examples of abuse include:

- A pattern of waiver of beneficiary (patient) cost-share or deductible
- Charging TRICARE beneficiaries rates for services and supplies that are in excess of those charged to the general public, such as by commercial insurance carriers or other federal health benefit entitlement programs
- A pattern of claims for services that are not medically necessary or, if necessary, not to the extent rendered
- Care of inferior quality (i.e., does not meet accepted standards of care)
- Failure to maintain adequate clinical or financial records
- Unauthorized use of the TRICARE® term in private business
- Refusal to furnish or allow access to records

Providers are cautioned that unbundling, fragmenting or code-gaming to manipulate the Current Procedural Technology (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 Office of Inspector General and other agencies investigate TRICARE fraud.

To report suspected fraud and/or abuse, call the Humana Military Fraud and Abuse Hotline at **1-800-333-1620**.

# Notes

# Behavioral Health Care Services

ValueOptions, Inc. is the behavioral health care contractor for Humana Military for the TRICARE South Region. ValueOptions administers the TRICARE behavioral health care benefit and manages the behavioral health care provider network.

ValueOptions reviews clinical information to determine if behavioral health care is medically or psychologically necessary. In certain circumstances, TRICARE waives behavioral health care benefit limits for medically or psychologically necessary services.

ValueOptions provider relations representatives are available to answer nonclinical questions, address concerns or assist with requests for additional information Monday through Friday, excluding federal holidays, at **1-800-700-8646**.

## Behavioral Health Care Providers

TRICARE covers services delivered by qualified, TRICARE-authorized behavioral health care providers practicing within the scope of their license to diagnose or treat covered behavioral health disorders. TRICARE encourages beneficiaries to receive behavioral health care at Military Treatment Facilities (MTFs), but beneficiaries may be referred to network providers if MTF care is not available.

The TRICARE behavioral health care outpatient network consists of TRICARE-authorized psychiatrists and other physicians, psychologists, social workers, marriage and family therapists, certified psychiatric nurse specialists, licensed or certified Mental Health Counselors (MHCs), and pastoral counselors.

To join the TRICARE network, a TRICARE-authorized provider must complete the credentialing process and sign a contract with ValueOptions for behavioral health. The following lists credentialing criteria for specific behavioral health care providers. See the *Important Provider Information* section for general credentialing criteria.

Psychiatrists and addictionologists must:

- Have an unrestricted license as an MD or DO in the state where services are provided or have received special state licensure if employed by a college or university.
- Have one of the following: board certification in psychiatry, evidence of having completed a residency program in psychiatry or certification from the American Society of Addiction Medicine (ASAM).
- Have a current Drug Enforcement Administration (DEA) certificate.
- Submit an Education Council for Foreign Medical Graduates (ECFMG) Certificate if a graduate of a foreign medical school.
- Be a participating Medicare provider.

Family practice and pediatric MDs and DOs must meet the following behavioral health criteria:

- Must meet the licensure, DEA and ECFMG criteria listed above for psychiatrists and addictionologists.
- Must have board certification in family practice or pediatrics with subcertification in developmental behavioral pediatrics or neurodevelopmental disabilities, ***or*** must provide evidence of completion of a residency program in family practice or pediatrics **and** a fellowship in developmental behavioral pediatrics, neurodevelopmental pediatrics or behavioral medicine.

Psychologists must:

- Have an unrestricted license to practice as a **clinical** psychologist in the state where services are provided.
- Have a doctoral degree in psychology (i.e., PhD, EdD or PsyD) from an accredited college or university.
- Be a participating Medicare provider.

Prescriptive privileges for psychologists (PhD): In select states within the United States, licensed clinical psychologists can obtain prescriptive privileges.

Nurse practitioners must:

- Have an unrestricted license to practice as a nurse practitioner with psychiatric nursing as the specialty in the state where services are provided.
- Must have a master's degree from an accredited college or university in a program recognized by the American Nursing Association (ANA).
- Be a participating Medicare provider.

Psychiatric nurses must:

- Have an unrestricted license to practice at the highest level of independent practice in the state where services are provided.
- Have a master's degree in psychiatric nursing from an accredited college or university in a program recognized by the American Nursing Association (ANA).
- Be certified by the American Nurses Credentialing Center (ANCC).

Social workers must:

- Have an unrestricted license to practice at the highest level of independent practice in the state where services are provided.

- Have a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education.
- Be a participating Medicare provider.

Marriage and family therapists must:

- Have an unrestricted license to practice at the highest level of independent practice in the state where services are provided.
- Have a master's degree from an accredited educational institution in an appropriate behavioral science field or mental health discipline.

TRICARE-certified Mental Health Counselors (MHCs) and other clinicians must:

- Have an unrestricted license to practice at the highest level of independent practice in the state where services are provided.
- Possess a master's or higher level degree from a mental health counseling program of education and training accredited for Mental Health Counseling or Clinical Mental Health Counseling by the Council for Accreditation of Counseling and Related Education Programs (CACREP) and have passed the National Counselor Examination (NCE) or possess a master's or higher level degree from a mental health counseling program of education and training accredited for Mental Health Counseling or Clinical Mental Health Counseling by CACREP or from an educational institution accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation and have passed the National Clinical Mental Health Counseling Examination (NCMHCE).

MHCs and other clinicians must:

- Have an unrestricted license to practice at the highest level of independent practice in the state where services are provided.
- Have a master's degree in mental health counseling or allied mental health field from a regionally accredited institution.

**Note:** Effective January 1, 2015, TRICARE will no longer recognize this category of provider.

Pastoral counselors must:

- Have an unrestricted license to practice as a pastoral counselor in the state where services are provided. In states that do not offer licensure, a pastoral counselor must be (or must meet all the requirements to become) a fellow or diplomat member in the American Association of Pastoral Counselors (AAPC).
- Have a master's degree in mental health counseling or allied mental health field from a regionally accredited institution.

ValueOptions does not credential Applied Behavior Analysis (ABA) providers, but those providers must contact ValueOptions to participate in the DoD Enhanced Access to Autism Services Demonstration. Providers who provide only Extended Care Health Option (ECHO) services are only required to be TRICARE-certified and do not need to contact ValueOptions. For more information on ECHO and the DoD Enhanced Access to Autism Services Demonstration, refer to the *TRICARE Program Options* section.

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).

ValueOptions also credentials the following types of facilities and health care delivery organizations:

- General hospitals with psychiatric services
- Acute freestanding psychiatric hospitals
- RTCs
- SUDRFs
- PHPs

# Referral and Authorization Requirements

TRICARE behavioral health care referral and authorization requirements vary according to several factors, including, but not limited to, beneficiary status, program option and type of care. Referral and prior authorization requirements for specific services are detailed later in this section, but the following general guidelines apply.

## Obtaining Referrals and Prior Authorizations

If a behavioral health care referral is necessary, submit authorization requests using the secure Self-Services for Providers portal at **Humana-Military.com**. Providers may also fax the *Outpatient Treatment Report* form to ValueOptions at **1-866-811-4422**. Search for **Behavioral Health Forms** at **Humana-Military.com** to download a copy of the form.

## Emergency Behavioral Health Care

Emergency care does not require prior authorization. However, the facility must report an admission to ValueOptions within 24 hours of the admission or the next business day (but must be within 72 hours of admission) to obtain authorization for continued stay.

## Outpatient Behavioral Health Care

Except for Active Duty Service Members (ADSMs), TRICARE beneficiaries may see a TRICARE-authorized provider for the first eight outpatient behavioral health care services per Fiscal Year (FY), which runs October 1 through September 30, for a medically diagnosed and covered condition without a Primary Care Manager (PCM) referral or authorization from Humana Military/ValueOptions.

Independent behavioral health care providers generally include psychiatrists or other physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers and certified marriage and family therapists.

**Note:** The first eight self-referred visits only apply to an initial appointment and any follow-up visits that are related to a diagnosed psychological or behavioral condition.

Although a PCM referral is never required for behavioral health care services, a behavioral health care provider must obtain prior authorization from ValueOptions for any visits exceeding the first eight in a FY. If a TRICARE Prime or TRICARE Prime Remote Active Duty Family Member (TPRADFM) obtains care from a non-network provider without prior authorization, Point-Of-Service (POS) fees will apply.

## Initial Evaluations

TRICARE only covers one initial evaluation — either a psychiatric diagnostic examination (Current Procedural Terminology [CPT®] code 90791) or a psychiatric diagnostic examination with medical services (CPT code 90792) — per FY. This initial evaluation counts toward the first eight self-referred outpatient visits.

Additional evaluations in the same FY require prior authorization from ValueOptions, regardless of whether the first eight visits have occurred. Submit requests for prior authorizations for additional evaluations using the secure Self-Service for Providers portal at **Humana-Military.com**.

Providers may also fax the *Outpatient Treatment Report* form to ValueOptions at **1-866-811-4422**. Search for **Behavioral Health Forms** at **Humana-Military.com** to download a copy of the form.

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

Physician referrals (i.e., MDs or DOs seeing the patient, performing an evaluation and making an initial diagnosis before referring the patient) and ongoing communication with referring physicians are required for all visits (including the first eight) to licensed or certified mental health and pastoral counselors.

The counselor must keep a copy of the referral in the patient's chart. This is a statutory and regulatory TRICARE program requirement that cannot be waived or altered. However, TRICARE-certified Mental Health Counselors (TCMHCs) who meet all requirements outlined in *TRICARE Policy Manual*, Chapter 11, Section 3.11, Paragraph 2.1.1.1 through 2.1.1.3 no longer require physician referral or ongoing communication.

When filing a claim, the counselor must indicate the referring physician's name in Box 17/17a/17b of the claim form to certify that he or she reported (or will report), in writing, treatment results to the referring physician as requested.

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

# Outpatient Services

TRICARE covers medically and psychologically necessary outpatient behavioral health care services, including outpatient psychotherapy, psychological testing and assessment, medication management, Applied Behavior Analysis (ABA), electroconvulsive therapy and telemental health services.

## Outpatient Psychotherapy

TRICARE covers medically and psychologically necessary outpatient psychotherapy used to treat covered behavioral health components of an otherwise diagnosed behavioral health or psychological condition. Services must be rendered by a qualified TRICARE-authorized behavioral health care provider practicing within the scope of his or her license to eligible TRICARE beneficiaries who have met any applicable requirements for a referral/authorization.

The following rules apply:

- A provider cannot bill for more than two sessions per calendar week (Sunday to Saturday) without prior authorization from ValueOptions.
- When multiple sessions of the same type are conducted on the same day (e.g., 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 (e.g., 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:

- Psychotherapy: two sessions per week, in any combination of the following types:
  - Individual (adult or child): 60 minutes per session, may extend to 120 minutes for crisis intervention
  - Family or conjoint: 90 minutes per session, may extend to 180 minutes for crisis intervention
  - Group: 90 minutes per session
- Collateral visits
- Psychoanalysis

For more information about outpatient psychotherapy, refer to the *TRICARE Policy Manual*, Chapter 7, Section 3.13 at **http://manuals.tricare.osd.mil/**.

## Psychological Testing and Assessment

TRICARE covers medically and psychologically necessary testing and assessment when provided in conjunction with otherwise-covered psychotherapy. Psychological tests are covered as diagnostic services and do not count toward the limit of two psychotherapy visits per week. Referrals and prior authorizations are not required when the rules outlined below are met.

Psychological testing is generally limited to six hours per year. ValueOptions may approve additional hours on a case-by-case basis. Submit authorization requests to ValueOptions using the secure Self-Services for Providers portal at **Humana-Military.com**.

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

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

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

For more information about psychological testing and assessment, refer to the *TRICARE Policy Manual*, Chapter 7, Section 3.12 at **http://manuals.tricare.osd.mil/**.

## Medication Management

TRICARE covers medication management when rendered by a provider who is authorized to prescribe the medication. Authorization from ValueOptions is required for medication management except for a patient's initial eight self-referred outpatient behavioral health care visits each FY. (ADSMs can't self-refer for outpatient behavioral health care visits.)

For more information about medication management, refer to the *TRICARE Policy Manual*, Chapter 7, Section 3.15 at **http://manuals.tricare.osd.mil/**.

## Applied Behavior Analysis

TRICARE covers ABA for all eligible beneficiaries with a diagnosis of Autism Spectrum Disorder (ASD). A referral from a TRICARE-authorized PCM or a specialized ASD provider is required for authorization of service.

Providers rendering ABA must be:

- TRICARE-authorized
- State-licensed, state-certified or, where state license or certification is not available, certified as a Board Certified Behavior Analyst (BCBA) to provide ABA services.

**Note:** Individuals certified as a Board Certified Assistant Behavior Analyst (BCaBA) are not TRICARE-authorized ABA providers under the TRICARE basic program.

For more information about Applied Behavior Analysis, refer to the *TRICARE Policy Manual*, Chapter 7, Section 3.18 at **http://manuals.tricare.osd.mil**.

## Electroconvulsive Therapy

TRICARE may cover medically and psychologically necessary electroconvulsive treatment rendered by a qualified provider. However, TRICARE does not cover using electric shock as negative reinforcement (aversion therapy).

## Telemental Health Services

Telemental health services involve using secure, two-way audiovisual conferencing to connect stateside TRICARE beneficiaries with offsite TRICARE network providers. Telemental health provides medically and psychologically necessary behavioral health care services, including:

- Clinical consultation
- Individual psychotherapy
- Psychiatric, diagnostic interview examination
- Medication management

Beneficiaries can access telemental health services at TRICARE-authorized telemental health-participating facilities by using a telecommunications system to contact TRICARE network providers at remote locations. Services rendered from a beneficiary's home are not covered by TRICARE.

Behavioral health care limitations, authorization requirements, deductibles and cost-shares apply. For more information, visit **www.TRICARE.mil/TelementalHealth**.

## Smoking Cessation Program

The Smoking Cessation Program provides telephone support and

referral services for non-Medicare-eligible TRICARE beneficiaries. The South Region Smoking Cessation Triage Line is available 24 hours a day, seven days a week toll-free at **1-877-414-9949**.

Licensed professionals provide free smoking cessation triage services by following the 5 A's model: Ask, Advise, Assess, Assist and Arrange. Beneficiaries who call will be assessed and receive guidance for a smoking cessation plan that fits their unique smoking habits.

There are **no** referral or authorization requirements associated with the service and no claims to be filed for services rendered. There is no cost to the beneficiary for use of the Smoking Cessation Triage Line.

For more information, search for **Smoking Cessation** at **Humana-Military.com**.

# Inpatient Services

All nonemergency admissions require prior authorization from ValueOptions.

A nonenrolled (i.e., non-TRICARE Prime) beneficiary may also be required to obtain a Nonavailability Statement (NAS) for a nonemergency inpatient admission. A NAS is a certification from an MTF stating that the MTF cannot provide a specific required service at a particular time to a nonenrolled beneficiary.

Before seeking nonemergency inpatient behavioral health care, the beneficiary should contact the beneficiary counseling and assistance coordinator at his or her local MTF to determine if a NAS is required. Prior authorization requirements still apply, regardless of NAS requirements.

## 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:

- Patients age 19 and older: 30 days per FY or in any single admission
- Patients 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. ValueOptions may approve additional days, as appropriate, based on medical necessity.

## Partial Hospitalization Program Care

Psychiatric PHPs provide interdisciplinary therapeutic services at least three hours a day, five days a week, in any combination of day, evening, night and weekend treatment programs. A full-day program lasts at least six hours, and a half-day program lasts between three and five hours.

PHPs employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. PHP care is appropriate for crisis stabilization, treatment of partially stabilized behavioral health disorders or transitioning a patient from an inpatient program when medically necessary.

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

- **Hospital-based PHP:** A hospital-based PHP does not need separate TRICARE certification from the TRICARE Quality Monitoring Contractor (TQMC). A PHP that is part of a TRICARE-authorized hospital is also considered TRICARE-authorized.
- **Freestanding PHP:** A freestanding PHP must be TRICARE-certified by the TQMC and must enter into a participation agreement with TRICARE. See the *Important Provider Information* section for more information.

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

The following coverage limitations apply:

- PHP care is considered elective (nonemergency) and always requires referral and prior authorization from ValueOptions.
- PHP care is limited to a maximum of 60 treatment days (full- or half-day program) per FY or for any single admission.
- PHP 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 not offset by, nor counted toward, the 30- or 45-day behavioral health care inpatient limit.

## Residential Treatment Center Care

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

The following rules apply:

- RTC care is considered elective (nonemergency) and always requires prior authorization from ValueOptions.
- Facilities must be TRICARE-authorized by the TQMC. (See the *Important Provider Information* section for contact information.)
- Unless therapeutically contraindicated, the family and/or guardian must actively participate in the continuing care

of the patient through either direct involvement at the facility or geographically distant family therapy.

- Admission primarily for substance use rehabilitation is not authorized.
- For admissions to an RTC, a psychiatrist or clinical psychologist must recommend admission and direct the treatment plan.

The following coverage limitations apply:

- Care is limited to 150 days per FY or for a single admission.
- RTC care is only covered for patients under age 21.

ValueOptions may approve additional days, as appropriate, based on medical necessity.

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.
- **RTC educational services:** Educational services are covered only when local, state or federal governments cannot provide appropriate education. TRICARE is always the last payer. For network providers, this limitation applies only if educational services are not part of the contracted per diem rate.
- **Non-behavioral health care services:** These services (e.g., 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 patient's condition requires the personnel and facilities of a hospital.

The following limits apply:

- Care is limited to seven days per episode in a TRICARE-authorized facility, if medically necessary.
- Services count toward the 30- or 45-day inpatient behavioral health care limit.
- Services do not count toward the 21-day rehabilitation limit.

## Inpatient Rehabilitation

Rehabilitation (residential or partial hospitalization) is limited to 21 days per year, per benefit period. A benefit period begins the first day of covered treatment and ends 365 days later.

The following rules apply:

- Prior authorization is always required for rehabilitation stays.
- Care may occur in an inpatient or partial hospitalization setting.
- Care is limited to 21 days per benefit period (combined partial and/or inpatient).
- All inpatient stays count toward the 30- or 45-day inpatient limit.
- Up to seven days of detoxification are allowed per episode in addition to the 21 rehabilitative days.
- Care must be provided in a TRICARE-authorized facility.
- A partial hospitalization rehabilitation stay counts toward the 60-day psychiatric PHP limit. (TRICARE shares the cost of this partial hospitalization rehabilitation treatment for up to 21 days at a predetermined, all-inclusive per diem rate.)
- TRICARE covers up to one treatment episode in a one-year period and up to three treatment episodes during the beneficiary's lifetime.

## Outpatient Care

An approved SUDRF must provide outpatient care.

The following coverage limits apply:

- Individual or group therapy: 60 visits per benefit period
- Family therapy: 15 visits per benefit period

A benefit period begins the first day of covered treatment and ends 365 days later. ValueOptions may approve additional visits, as appropriate, based on medical necessity.

TRICARE does not cover non-facility-based outpatient services provided in an office-based setting for a beneficiary with a primary diagnosis of substance use disorder/dependence.

# Court-Ordered Care

TRICARE defines court-ordered care as outpatient and inpatient medical services that a party in a legal proceeding is ordered or directed to obtain by a court of law. The fact that medical services are ordered by a court does not determine the coverage of those medical services.

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 covered conditions and are for covered TRICARE services provided by authorized providers to eligible TRICARE beneficiaries who have met any applicable requirements for a referral/authorization. The services must be at the appropriate level of care to treat the condition, and the beneficiary (or the beneficiary's family) must have a legal obligation to pay for the services.

# Behavioral Health Care Management

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

## Prospective Review

Prospective review is conducted when a certain procedure or service requires a medical necessity review. The review is performed under the direction of a behavioral health care clinician.

The purpose of a prospective review is to:

- Determine medical necessity.
- Evaluate the proposed treatment.
- Assess the level of care required.
- Determine the appropriate level of care prior to admission.
- Identify potential for discharge planning needs.
- Determine whether the case meets care coordination or case management criteria.
- Identify potential quality-of-care issues.

Depending on first-level (i.e., prospective) review results, ValueOptions either authorizes the service or refers the service for a second-level review by a physician and/or peer reviewer. A prospective review never results in a denial of care or treatment.

## Concurrent Review

A concurrent review is a process of continual reassessment of the beneficiary's needs during treatment. The behavioral health care clinician responsible for concurrent review evaluates the beneficiary's level-of-care needs during hospitalization. Based on medical determinations, an entire episode of medical care may be adapted to fit the beneficiary's status and needs.

Concurrent review activities monitor appropriateness of the level of care and identify potential care coordination, discharge needs and case-management candidacy. A concurrent review may also include:

- A continuum of health care based on identified needs and goals
- Design and adaptation of health care initiatives for the beneficiary
- Identification of assistance needs throughout an entire episode of care
- Beneficiary and family education

Providers can request a concurrent review via the secure Self-Service for Providers portal at **Humana-Military.com**. Providers may also fax the *TRICARE Higher Level of Care Treatment* form to ValueOptions at **1-866-811-4422**. Search for **Behavioral Health Forms** at **Humana-Military.com** to download a copy of the form.

## Retrospective/Prepayment Review

When treatment falls within the behavioral health care ICD-9 code range of 290.0 to 319, the provider must submit a retrospective review request to ValueOptions via the secure Self-Service for Providers portal at **Humana-Military.com** or fax a request to **1-866-811-4422**.

Non-network care rendered without authorization may be subject to prepayment review. Non-network claims submitted without prior authorization are deferred for prepayment review, which may require access to the patient's medical record to determine medical necessity and TRICARE coverage. Penalties may also apply.

To initiate a retrospective review for denied claims, mail a request and a copy of the medical record to:

ValueOptions
Retrospective Review
P.O. Box 551188
Jacksonville, FL 32255-1188

To initiate a retrospective review for outpatient care beyond the initial eight self-referred visits, mail a *TRICARE Outpatient Retrospective Review Form* to the above address or fax the information to ValueOptions at **1-866-811-4422**. Search for **Behavioral Health Forms** at **Humana-Military.com** to download a copy of the form.

## Case Management

Certain beneficiaries require more intensive care management and coordination. These high-risk beneficiaries may be eligible for case management through ValueOptions.

Case management identifies links and provides intensive coordination of behavioral health care and substance use disorder services to help beneficiaries maintain clinical stability. Case managers link beneficiaries with TRICARE resources, MTFs, and state, federal and local community resources, and they teach beneficiaries to be proactive about accessing care.

To refer a patient for a case management evaluation, call ValueOptions at **1-800-700-8646** or submit the *Case Management Behavioral Health Referral Form*. Search for **Behavioral Health Forms** at **Humana-Military.com** to download a copy of the form.

If ValueOptions accepts the case for management services, a case manager will contact the beneficiary.

## Discharge Planning

Discharge planning facilitates the transition of the beneficiary to a less-restrictive level of care. Behavioral health care providers are expected to include discharge planning as a routine part of treatment.

Discharge planning services are automatically considered for all TRICARE beneficiaries in facilities where ValueOptions provides utilization management services. Discharge planning objectives include:

- Ensure appropriate use of health care services and hospital resources.
- Evaluate acuity of the cases to project resources necessary for positive discharge planning.
- Identify and use cost-effective care sites when clinically appropriate.
- Ensure appropriate admissions and avoid readmissions due to incomplete treatments.
- Identify and use all alternative sources of available funding.
- Ensure coordination with external entities.

The provider/facility should inform the patient about specific discharge plans and aftercare treatments, including detailed placement plans and follow-up care. Aftercare appointments should occur within seven days after discharge and no later than 30 days after discharge.

ValueOptions must authorize all medically necessary aftercare services to ensure continuity of care. Submit authorization requests to ValueOptions using the secure Self-Services for Providers portal at **Humana-Military.com**.

Providers may also fax the *TRICARE Higher Level of Care Treatment* form to ValueOptions at **1-866-811-4422**. Search for **Behavioral Health Forms** at **Humana-Military.com** to download a copy of the form.

# Incident Reporting Requirements

Any serious occurrence involving a TRICARE beneficiary while receiving services at a TRICARE-authorized treatment program (e.g., RTC, freestanding PHP or SUDRF) must be reported to ValueOptions and the TQMC within one business day. TRICARE participation agreements outline specific requirements.

Reportable occurrences as defined by TRICARE include:

- Life-threatening accident
- Patient death
- Patient elopement
- Suicide attempt
- Cruel or abusive treatment
- Physical or sexual abuse
- Any equally dangerous situation

The point of contact for TRICARE incident reporting is the TQMC. See the *Important Provider Information* section for more information.

# Limitations and Exclusions (Behavioral Health)

The following is a list of behavioral health care services that are generally not covered under TRICARE or are covered with significant limitations. **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
- Biofeedback for psychosomatic conditions
- Counseling services 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
- Experimental procedures
- Marathon therapy
- Megavitamin or orthomolecular therapy
- Psychosurgery (Surgery for the relief of movement disorders, electroshock treatments and surgery to interrupt the transmission of pain along sensory pathways are not considered psychosurgery.)
- Services and supplies not medically or psychologically necessary for the diagnosis and treatment of a covered condition
- Services for V-code or Z-code diagnoses
- Sexual dysfunction therapy
- Surgery performed primarily for psychological reasons (e.g., psychogenic)
- Therapy for developmental disorders, such as dyslexia, developmental mathematics disorders, developmental language disorders and developmental articulation disorders
- Unproven drugs, devices and medical treatments or procedures

## Sexual Disorders

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

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

- Gender identity disorders (characterized by strong and persistent cross-gender identification accompanied by persistent discomfort with one's assigned gender)
- Orgasmic disorders (e.g., female orgasmic disorder, male orgasmic disorder, premature ejaculation)
- Paraphilias (e.g., exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism and paraphilia not otherwise specified)
- Sexual arousal disorders (e.g., female sexual arousal disorder, male erectile disorder)
- Sexual desire disorders (e.g., hypoactive sexual desire disorder, sexual aversion disorder)
- Sexual dysfunction due to a general medical condition
- Sexual dysfunctions not otherwise specified, including those with organic or psychogenic origins
- Sexual pain disorders (e.g., dyspareunia, vaginismus)
- Substance-induced sexual dysfunction

# Notes

# Claims Processing and Billing Information

## South Region Claims Processor

### PGBA, LLC

PGBA is the Humana Military contractor for claims processing in the TRICARE South Region. Visit PGBA's website at **www.myTRICARE.com** for more information about PGBA and claims processing for TRICARE.

TRICARE network providers must file patients' TRICARE claims, even when the patient has Other Health Insurance (OHI). Payments made to network providers for medical services rendered will not exceed 100 percent of the TRICARE allowable charge, also known as Civilian Health and Medical Program of the Uniformed Services Maximum Allowable Charge (CMAC). Visit **www.TRICARE.mil/CMAC** to find the fee schedules.

## Claims Processing Standards

### HIPAA National Provider Identifier Compliance

TRICARE requires providers to file claims electronically with the appropriate Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant standard electronic claims format. Non-network providers submitting paper claims must use either a CMS-1500 (professional charges) or a UB-04 (institutional charges) claim form.

The National Provider Identifier (NPI) is a 10-digit number used to identify providers in standard electronic transactions. It is a HIPAA requirement.

Providers must submit the appropriate NPI on all HIPAA-standard electronic transactions. Both billing NPIs and rendering provider NPIs, when applicable, are required when filing claims. Providers treating TRICARE beneficiaries as a result of referrals should also include the referring provider's NPI on transactions, if available, per the implementation guide for the transaction.

Both individual providers (Type 1) and organizational providers (Type 2) should register all NPIs with Humana Military. The easiest way to do this is via the secure Self-Service for Providers portal at **Humana-Military.com**.

### HIPAA Transaction Standards and Code Sets

Providers must use the following HIPAA standard formats for TRICARE claims:

- ASC X12N 837—Health Care Claim: Professional, Version 5010 and Errata
- ASC X12N 837—Health Care Claim: Institutional, Version 5010 and Errata

TRICARE contractors and other health care payers are prohibited from accepting or issuing transactions that do not meet HIPAA standards. To avoid cash-flow disruptions, it is imperative that providers use the HIPAA-compliant claims formats.

For assistance with HIPAA standard formats for TRICARE, call PGBA's TRICARE Electronic Data Interchange (EDI) Help Desk at **1-800-325-5920**, menu option 2.

### Signature on File Requirements

Providers must keep a "signature on file" for TRICARE-eligible beneficiaries 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 CMS-1500 claim form.

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 age 18 or older who are incapable of providing signatures may have a legal guardian appointed or a power 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 must 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. Providers should consult qualified legal counsel concerning signature requirements in particular circumstances involving mental or physical incapacity.

## Billing and Filing Guidelines

The following information provides guidelines for processing claims in the TRICARE South Region.

- TRICARE network providers must file all claims electronically. (See *Electronic Claims Submission* later in this section.)

- Where TRICARE is the secondary payer, the 90-day claims filing period will commence once the primary payer has made payment or denied the claim.

- During a TRICARE program phase-out period (i.e., the end of one TRICARE contract and the start of a new one), network providers must use their best efforts to submit TRICARE claims within 30 days from the date services are rendered or the date of the primary payer's Explanation Of Benefits (EOB).

## Important Billing Tips

There are several reasons why claims are delayed or denied unnecessarily. Here are some helpful billing tips to help facilitate prompt claims processing.

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 to the billing.

**Active Duty Service Member (ADSM) claims**
Send TRICARE Prime Remote (TPR) and Supplemental Health Care Program (SHCP) claims to PGBA for processing and payment. ADSM claims will be paid at the same negotiated rate as stated in the provider's contracted agreement.

There are no copays, cost-shares or deductibles for ADSMs or Active Duty Family Members (ADFMs) enrolled in TPR. For ADFMs, the copay, cost-share and deductible waiver do not apply to pharmacy copays, the Extended Care Health Option (ECHO) cost-shares or Point-Of-Service (POS) cost-shares and deductibles.

The same balance billing limitations applicable to TRICARE apply to SHCP. For more information, see *Balance Billing* in the *Important Provider Information* section.

**Admitting diagnosis**
The admitting diagnosis is required on all inpatient claims.

**Anesthesia claims**
Claims 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.

**Beneficiaries eligible for Medicare and TRICARE**
For beneficiaries who are eligible for Medicare and TRICARE, submit Medicare claims first. Claims will automatically be transmitted from Medicare to TRICARE for secondary claims processing, and Wisconsin Physicians Service/TRICARE Dual Eligible Fiscal Intermediary Contract (WPS/TDEFIC) will process the TRICARE portion of the claim. Refer to *Claims for Beneficiaries Using Medicare and TRICARE* later in this section.

**Claims corrections**
For information on submitting corrected claims electronically, refer to the *PGBA HIPAA Companion Guides* for 837 claims on **www.myTRICARE.com**.

**Demographic changes**
Providers must inform Humana Military of any changes that occur in professional affiliation, Tax Identification Number (TIN), office location or telephone number. All providers can update their information through **myTRICARE.com**. See *Updating Provider Information* in the *Important Provider Information* section.

In addition, Humana Military will contact network providers periodically to verify provider demographic information, panel status and their ability to meet office appointment and access standards.

**ICD-9 or ICD-10/DSM-IV codes**
When billing ICD-9-CM diagnosis codes, code services to the highest level of specificity (i.e., five-digit level). When billing ICD-10-CM diagnosis codes on or after October 1, 2014, code services to the highest level of specificity (i.e., seven-digit level). DSM-IV codes are required for behavioral health conditions.

**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.

**NPIs**
Include all applicable NPIs. See *HIPAA National Provider Identifier Compliance* for more information.

**Out-of-region claims**
Submit claims to the TRICARE region where the beneficiary is enrolled. Refer to *Processing Claims for Out-of-Region Care* later in this section.

**Place of service codes**
Use the correct place of service codes.

**Services that require specific units of service**
When billing for these services, such as allergy testing and treatment, code units of service based on the description in the most current edition of the CPT publication.

**Third-Party Liability (TPL)**
If billing for care that may involve TPL (diagnosis codes 800 to 999 for ICD-9; for ICD-10-CM codes on or after October 1, 2014, use S00-T98), instruct the beneficiary to promptly respond to any request for TPL information. Once the beneficiary returns the signed *Statement of Personal Injury—Possible Third Party Liability* (DD Form 2527) form to Humana Military, PGBA will process the claim.

**Timely submission**
Providers must submit all TRICARE provider claims to PGBA for payment within one year of the date the service was rendered.

**Unlisted or unspecific Current Procedural Terminology (CPT®) codes**
When submitting a paper claim and billing with an unlisted or unspecified CPT procedure code, providers must include supporting documentation describing the services rendered, or PGBA will return

the claim for this information. For electronic claims, include the codes, and PGBA will request additional information when applicable.

# Electronic Claims Submission

Electronic Media Claims (EMC) submission allows providers to submit claims directly to Humana Military and PGBA, ensuring faster processing and reduced paperwork. TRICARE network providers should file all claims electronically using one of Humana Military's EMC options.

## Benefits of EMC Submission

Electronic Media Claims (EMC) submission offers many advantages, particularly increased cash flow by cutting down processing time and helping prevent rejected claims. Here are some more benefits of EMC submission:

- Decrease in time for receipt of payment: EMC submission reduces the time for payment by automatically denying claims with errors, returning them to the provider for corrections.
- Improve claim reporting by observation of errors: Submitting claims electronically helps provider see what causes claim rejections and allows providers to modify their method of relating claim information to prevent similar errors.
- Reduce errors through pre-editing claims information: EMC claims pre-edited for errors have a much higher payment ratio.
- Take advantage of technology already in place: Many practice management systems have an electronic claim component included or available at minimal cost.
- Reduce paper administration and costs: Providers no longer need to print and mail claims with EMC submission, saving money on supplies, equipment and postage.
- Speed up the claims process: Enjoy faster claims processing, avoid mailing delays and receive reimbursement more quickly.
- Receive claim status information: Systems automatically generate notifications of receipt of claims or rejection of claims due to missing or invalid information.

## EMC Filing Options

Humana Military recommends the following options for EMC submission:

**XPressClaim®**
XPressClaim is a fast, easy and free real-time online claims processing system available at **www.myTRICARE.com**. Providers can reconcile claims payments, check claims status and check OHI information using online tools.

With XPressClaim, providers can submit secure TRICARE CMS-1500 and UB-04 claims and receive instant payment results. They can also print a patient summary receipt while the patient is still in the office.

There is no cost to use XPressClaim. To sign up, go to **www.myTRICARE.com** and search for **XPressClaim**.

**eZ TRICARE Claims**
With eZ TRICARE Claims, network providers can upload batches of claims directly from their practice management system. There is no software to install, no data entry and no cost to file TRICARE claims.

eZ TRICARE Claims can accept a variety of claims formats, including National Standard Format, ASC X12 837, and CMS-1500 or UB-04 print files. To sign up for eZ TRICARE Claims, log in to the secure Self-Service for Providers portal at **Humana-Military.com**.

**Claims Clearinghouses**
Humana Military receives TRICARE claims from a large number of EMC clearinghouses. Providers should contact their clearinghouse to find out what they need to do to send TRICARE claims to PGBA. Depending on the clearinghouse, Humana Military's payer listing could be Humana Military, Humana Military Healthcare Services, PGBA or TRICARE South.

**Electronic Data Interchange Gateway**
For providers who have systems that can create HIPAA-compliant claims formats and who prefer to send claims directly to the payer, PGBA's EDI Gateway may be the right option. PGBA built the EDI Gateway to handle all of its inbound and outbound HIPAA-compliant EDI transactions.

The communications protocols supported are Asynchronous Dial-up, File Transfer Protocol (FTP) and CONNECT: Direct/NDM. To enroll or learn more about the EDI Gateway, contact the TRICARE EDI Help Desk at **1-800-325-5920**, menu option 2.

## EDI Gateway Provisions

Network providers submitting claims and conducting other transactions through EDI agree to the following provisions constituting a trading partner agreement to comply with the *TRICARE Operations Manual*, Chapter 21, Section 3 at **http://manuals.tricare.osd.mil**.

1. The provider may not disclose any Protected Health Information (PHI) concerning a TRICARE beneficiary to any third party, except Humana Military, its claims processing subcontractor or the TRICARE Management Activity (TMA), without the written consent of the TRICARE beneficiary or his or her authorized representative, or where disclosure is necessary for the care and treatment of the beneficiary, for the purpose of payment for the services provided by the provider or as otherwise authorized or required by state or federal law.
2. The provider may submit claims only on behalf of those TRICARE beneficiaries who give their written

authorization and must certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file with the provider. For eligibility transactions, eligibility does not indicate authorization for services.

3. The provider must ensure every electronic entry can be readily associated and identified with an original source document. Each source document must reflect all of the following information:

    - Beneficiary's name
    - Beneficiary's health insurance claim number
    - Date(s) of service
    - Diagnosis/nature of illness
    - Procedure/service performed

4. The provider agrees that TMA, or its designee, has the right to audit and confirm information submitted by the provider and will have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization. All incorrect payments that are discovered as a result of such an audit will be adjusted according to the applicable provisions of the TRICARE program regulations, policies and guidelines.

5. The provider must retain all original source documentation and medical records pertaining to any such particular TRICARE claim for a period of at least seven years after the claim is processed.

6. The provider must affix his or her unique identifier number, assigned by the claims processor, on each claim electronically transmitted to the contractor.

7. The provider agrees that each and every claim submitted electronically, for all legal and other purposes, will be considered signed by the provider or the provider's authorized representative.

8. The provider must implement sufficient security procedures to ensure that all transmissions of documents are authorized and to protect all beneficiary-specific data from improper access by third parties.

9. The provider acknowledges that all claims for services provided to TRICARE beneficiaries are paid from federal funds and that the submission of such claims is a claim for payment under the TRICARE program.

10. The provider will notify the claims processor within two business days if any transmitted data are received in an unintelligible or garbled form.

11. Transmission format: All standard transactions, as defined by Social Security Act Section 1173(a) and the Transaction and Code Sets Final Rules, conducted between Humana Military or the claims processor and the provider or any business associate, will only use code sets, data elements and formats specified by the Transaction and Code Sets Final Rules and the then-current version of the *PGBA, LLC Supplemental Implementation Guides*. The *PGBA, LLC Supplemental Implementation Guides* and any updates or amendments thereto may be accessed at **www.myTRICARE.com** and are incorporated herein by reference. This section will automatically amend to comply with any final regulation or amendment to a final regulation adopted by U.S. Department of Health and Human Services concerning the subject matter of this section upon the effective date of the final regulation or amendment.

# Other Helpful Hints

## TRICARE EDI Help Desk

PGBA operates a TRICARE EDI Help Desk to assist providers with any issues related to TRICARE EMC submissions. The telephone number is **1-800-325-5920**, menu option 2. Callers should identify themselves as a TRICARE provider.

## Supporting Documentation

TRICARE claims requiring hard-copy supporting documentation can still be filed with the claim electronically. PGBA maintains dedicated fax numbers to receive supporting documentation for electronically submitted claims.

Use the *EDI Support Documentation* form to ensure the documentation is correctly matched to the claim. Search for **EDI Support Documentation** at **Humana-Military.com** to download the form. The form lists the dedicated fax numbers.

## Claims with OHI

When filing claims that have OHI, providers can avoid sending a hard-copy EOB from the primary payer by transmitting the required information electronically. PGBA needs to know the amount the primary insurance paid.

If the primary insurance is a preferred provider organization, health maintenance organization, Medicare or other insurance where there is a limited liability for the patient, then providers also must indicate the OHI-allowed amount. The OHI-allowed amount represents the amount paid by the primary insurer, plus any out-of-pocket expenses owed by the patient.

In cases where the primary insurance paid zero, include the reason nothing was paid.

**Note:** Providers may not bill the beneficiary for cost-shares or copays when OHI has paid more than the contractual TRICARE allowable charge.

## EMC Response Reports

To ensure that electronic TRICARE claims are accepted by PGBA's system for processing, it is imperative that providers reconcile EMC transmissions with the EMC response reports returned by PGBA for every transmission.

These responses show the claims that were rejected as well as the claims that were accepted for processing. Review these responses to ensure that EMC transmissions are not lost and to identify rejected claims to correct and resubmit them electronically for processing.

If TRICARE claims are submitted through a clearinghouse or other vendor, the PGBA responses are returned to that entity. Many clearinghouses perform their own edits and create their own reports showing how many claims were received from the provider and forwarded on to the payer, but only the PGBA responses show which claims were received and accepted by PGBA for processing.

Providers that are not sure if they are receiving these PGBA EMC responses should contact their vendor or PGBA's TRICARE EDI Help Desk at **1-800-325-5920**, menu option 2.

### 5010

As of August 1, 2012, all trading partners covered by HIPAA must submit inquiries and claims using the 5010 format. The covered transactions for TRICARE include:

- 270/271—Health Care Eligibility Benefit Inquiry and Response
- 276/277—Health Care Claim Status Request and Response
- 835—Health Care Claim Payment/Advice
- 837—Health Care Claim (Professional and Institutional)

### Common EMC Rejections

PGBA maintains a list of common EMC rejection reasons and solutions. Search for **EDI Billing Tips** at **www.myTRICARE.com**.

## EFT/ERA

To help streamline claims, Humana Military also encourages providers to sign up for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA), also known as an EOB. ERAs are the electronic versions of the paper remittance advices received in the mail. EFTs are electronic payments deposited directly into a provider's bank account.

Going paperless offers many advantages:

- Improved cash flow by eliminating mail time and bank float
- Elimination of bank fees for depositing paper checks or lockbox processing
- No more paper checks to physically track or deposit
- Online access to old paper remits if needed at **www.myTRICARE.com**
- Automated payment posting capabilities that streamline administrative processing functions
- Elimination of PHI being available in paper documents on someone's desk or lost in the mail

ERAs are available to any provider who requests access, and providers can retrieve ERAs using one of two ways: an imaged ERA that looks similar to the paper version and a HIPPA-compliant 835 file, which providers can download and use to post payments automatically.

### EFT/ERA Enrollment

To enroll in EFT/ERA, go to **www.MyTRICARE.com**, select **Provider Forms** at the bottom and click **EFT/ERA Enrollment Form** to begin the process. Once PGBA receives and processes the completed enrollment form, ERA setup takes 48 to 72 hours, and EFT setup takes five to seven business days.

For assistance, call PGBA's TRICARE EDI Help Desk at **1-800-325-5920**, menu option 2.

## Filing Paper Claims

When filing paper claims, complete the CMS-1500 or UB-04 accurately and fully. Submit paper claims to:

TRICARE South Region
Claims Department
P.O. Box 7031
Camden, SC 29020-7031

Follow these guidelines:

- Use the most appropriate CPT code when billing TRICARE; do not unbundle charges into separate CPT codes when a single code is more appropriate.
- If the CPT code being billing does not match the services authorized, the claim will be denied.
- Institutional providers billing with certain revenue codes must submit Level II HCPCS codes for service and supply descriptions.
- The provider's signature is required on all claims, including the UB-04 institutional claim form. In lieu of the provider's actual signature, a facsimile signature or a representative's signature will be accepted if TRICARE has the proper authorization forms on file. Claims submitted without the proper signature will be returned or denied.

Because the provider's signature block FL was eliminated from the UB-04, the National Uniform Billing Committee has designated FL 80 (Remarks) as the location for the non-network provider signature if signature-on-file requirements do not apply to the claim. The TRICARE South Region has implemented a signature-on-file capability for non-network providers. Contact PGBA for details.

To ensure TRICARE has the appropriate signature authorization forms on file, refer to the *TRICARE Operations Manual*, Chapter 8, Section 4 at **http://manuals.tricare.osd.mil**.

## Checking the Status of Claims

Providers can check the status of claims using the secure Self-Service for Providers portal at **Humana-Military.com**. They can

also log in to **www.myTRICARE.com** or call PGBA's Interactive Voice Response (IVR) line at **1-800-403-3950**. IVR is available 24 hours a day, seven days a week.

To check the status of a claim in writing or to resubmit a claim, address correspondence to:

TRICARE South Region
Customer Service Department
P.O. Box 7032
Camden, SC 29020-7032

# Returning Incorrect Payments

If providers receive a duplicate payment or overpayment for a claim for TRICARE beneficiaries, Humana Military requests that they return this payment to PGBA's TRICARE Finance Department. Please include a copy of the remittance advice and a cover letter explaining exactly why the payment is being returned.

If not including a remittance advice, please provide information about the beneficiary and the claim (including the recoupment case number) to help ensure the refund is credited to the correct claim.

Return duplicate payments or overpayments to:

PGBA
ATTN: TRICARE Finance
TRICARE Refunds/AG900 PGBA
P.O. Box 100279
Columbia, SC 29219-3279

Return duplicate payments or overpayments for TRICARE For Life (TFL) claims to WPS/TDEFIC:

WPS/TDEFIC
ATTN: Refund
P.O. Box 7928
Madison, WI 53707-7928

If providers do not return the overpayment, then PGBA may, after written notice, offset the amount of double payment against future claim payments.

# Billing with ICD-9 V Codes or ICD-10 Z Codes

For dates of service prior to October 1, 2014, use the correct V code diagnosis to indicate the reason for the visit. For dates of service on or after October 1, 2014, be sure to use the correct Z code.

The V or Z code must match the CPT/HCPCS code to indicate the procedure that the provider performed as it correlates to the V code or Z code diagnosis. These codes correspond to descriptive, generic, preventive, ancillary or required medical services and should be billed accordingly.

Here is an overview of different types of V or Z codes and their uses. Claims not following the guidelines outlined below for using V or Z codes as a primary diagnosis are subject to denial for insufficient diagnosis.

## Descriptive V Codes

For V codes providing descriptive information as the reason for the patient encounter, designate that as the primary diagnosis. An example of a descriptive V code is a routine infant or child health visit, which is designated as V20.2.

## Generic V Codes

For ancillary diagnostic or therapeutic services, do not use a generic V code as a primary diagnosis unless the diagnosis or problem for which the ancillary service being performed is also reported. For example, a V code for a radiologic exam (V72.5) followed by the code for wheezing (786.07) or chest pain (786.50) is acceptable.

## Preventive V Codes

For preventive services, a V code describing a personal or family history of a medical condition is sufficient as a primary diagnosis without the need for additional diagnostic information. Examples are a mammography, Pap smear or Fecal Occult Blood Test (FOBT) screening.

## Descriptive Z Codes

For Z codes providing descriptive information as the reason for the patient visit, designate that description as the primary diagnosis. An example of a descriptive Z code is a routine infant or child health visit, which is designated as Z00.121, Z00.129, Z00.2, Z00.70 or Z00.71.

## Generic Z Codes

For ancillary diagnostic or therapeutic services, do not use a generic Z code as a primary diagnosis unless the diagnosis or problem for which the ancillary service being performed is also reported. For example, using the Z code Z01.89 (Encounter for the other specified [radiologic not associated with procedure] special examinations) followed by the code for wheezing (R06.2) or chest pain on breathing (R07.1) is acceptable.

## Preventive Z Codes

For preventive services, a Z code describing a personal or family history of a medical condition is sufficient as a primary diagnosis without the need for additional diagnostic information. Examples are a mammography, Pap smear or FOBT screening.

# Allergy Testing and Treatment Claims

TRICARE does not cover unproven allergy testing or treatment. For a list of unproven allergy testing and treatments, refer to *TRICARE Policy Manual*, Chapter 7, Section 14.1 at **http://manuals.tricare.osd.mil**.

When submitting claims for allergy testing and treatment, use the appropriate CPT code and indicate the type and number of allergy tests performed on the claim form.

When filing claims for the administration of multiple allergy tests,

group the total number of tests according to the most current CPT 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 (e.g., one set, two or more sets).

## Global Maternity Claims

Global maternity involves the billing process for maternity-related beneficiary claims. After confirming a patient is pregnant, all charges related to the pregnancy are grouped under one global maternity diagnosis code.

When billing, list the appropriate pregnancy diagnosis code as the primary diagnosis. Figure 8.1 lists examples of these codes.

## Global Maternity Diagnosis Code Examples Figure 8.1

| **ICD-9 Codes (*before 10/1/2014*)** | **ICD-10 Codes (*on or after 10/1/2014*)** | **Description** |
|---|---|---|
| V22 | Z34 | Normal pregnancy |
| V22.0 | Z34.00, Z34.01, Z34.02, Z34.03 | Supervision of normal first pregnancy |
| V22.1 | Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93 | Supervision of other normal pregnancy |
| V22.2 | Z33.1 | Pregnant state, incidental |

When TRICARE Prime, TPR and TRICARE Prime Remote for ADFMs (TPRADFM) beneficiaries are referred for specialty obstetric care, they must obtain prior authorization for both outpatient and inpatient services.

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.
- Evaluate the fetus' condition in late registrants for prenatal care.

Maternal Serum Alpha Fetoprotein Screenings and Multiple Marker Screen Tests 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 visit. 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 Claims Filing

For injectables administered in the office, bill the appropriate Healthcare Common Procedure Coding System (HCPCS) code for the administered injectable.

When billing for a drug for which there is no defined allowable in the Medicare J Code Pricing File, provide the appropriate HCPCS code and the applicable National Drug Code (NDC) printed on the manufacturer's drug packaging label (use 11-digit format) in Column 24D (NDC, Unit/basis of measurement qualifier, Drug Quantity in 24D) of the CMS-1500 claim form. Ensure the appropriate HCPCS units are indicated in Column 24G of the CMS-1500 claim form for pricing from the HCPCS code.

**Note:** Some drugs will price from the HCPCS Code and HCPCS units, and other drugs will price from the NDC, unit of measurement and drug quantity.

The NDC number, drug quantity and package unit indicators are necessary on drug and vaccine claim filings for appropriate pricing. Visit **www.TRICARE.mil/CMAC** to determine if a TRICARE allowable charge exists for specific drugs or vaccines.

EMC 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. If submitting this form to PGBA through Faxgate, it will be attached to the electronic claim.

CMS-1500 paper 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.

If needed, please include supporting documentation (such as CMN, medical records or NDC information) with the claim submission.

For more injectable billing tips, search for **Provider Office Injectables Guidelines** at **Humana-Military.com**.

### Home Infusion Injectables

Keep the following in mind when filing claims for home infusion medications:

- List the NDC number, units and unit of measurement on the gray line above the HCPCS code if filing using a CMS-1500 claim form.
- Report the NDC number in the 11-digit format.
- Use the Noridian Crosswalk Table to convert the HCPCS units into NDC units. Submit the UOM as units (UN, ML or GR).
- Place of service must be Home.
- If infusion therapy is performed in an ambulatory infusion suite, the place of service must be Office, and submit the HCPCS with modifier SS.

For more home infusion injectable billing tips, search for **Home Infusion Injectables Guidelines** at **Humana-Military.com**.

## Processing Claims for Out-of-Region Care

When providing health care services to a TRICARE beneficiary who is enrolled in a different region, the beneficiary will pay the applicable cost-share, and providers must 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.

For claims issue or questions regarding a TRICARE patient who normally receives care in another TRICARE region, call the appropriate region-specific number for assistance.

### North Region
### 1-877-TRICARE (1-877-874-2273)

The North Region includes Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Iowa (Rock Island Arsenal area only), Kentucky (excluding the Fort Campbell area), Maine, Maryland, Massachusetts, Michigan, Missouri (St. Louis area only), New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia and Wisconsin.

### 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 (El Paso area only), Utah, Washington and Wyoming.

## TRICARE Overseas/Foreign Claims

International SOS Assistance, Inc. administers the TRICARE program overseas and handles claims processing for all overseas claims. This includes TFL claims for medical care received outside the United States and its territories.

If filing a claim for an ADSM who is enrolled in a TRICARE Overseas Program (TOP) option (TOP Prime, TOP Prime Remote or TOP Standard), submit it to the address listed in Figure 8.2. If filing a claim for a non-ADSM who is enrolled in a TOP option, submit it to one of the addresses listed in Figure 8.3.

Overseas claims for National Guard and Reserve members on orders of 30 days or less must also be sent to International SOS. To expedite claims, the provider should submit a copy of the member's orders with the claim. The orders verify the member's eligibility for TRICARE benefits.

For more information, visit **www.TRICARE-overseas.com** or call International SOS at **1-877-451-8659**.

## TRICARE Overseas Claims Contact Information — ADSMs

Figure 8.2

| | |
|---|---|
| **All Overseas Areas** | TRICARE Overseas Program<br>P.O. Box 7968<br>Madison, WI 53707-7968 |

## TRICARE Overseas Claims Contact Information — Non-ADSMs

Figure 8.3

| | |
|---|---|
| **TRICARE Eurasia-Africa** (Africa, Europe and the Middle East) | TRICARE Overseas Program<br>P.O. Box 8976<br>Madison, WI 53708-8976 |
| **TRICARE Latin America and Canada** (Canada, the Caribbean Basin, Central and South America, Puerto Rico and the U.S. Virgin Islands) | TRICARE Overseas Program<br>P.O. Box 7985<br>Madison, WI 53707-7985 |
| **TRICARE Pacific** (Asia, Guam, India, Japan, Korea, New Zealand and Western Pacific remote countries) | TRICARE Overseas Program<br>P.O. Box 7985<br>Madison, WI 53707-7985 |

## Claims for Beneficiaries Assigned to US Family Health Plan Designated Providers

Designated providers are facilities that have contracts with the DoD to provide care to beneficiaries enrolled in the US Family Health Plan (USFHP). 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 Humana Military. The designated provider is responsible for all medical care for a USFHP enrollee, including pharmacy services, primary care and specialty care.

If providing care to a USFHP enrollee outside of the network or in an emergency situation, file claims with the appropriate designated provider at one of the addresses listed in Figure 8.4. Do not file USFHP claims with Humana Military.

For more information, visit **www.USFHP.com**.

## Claims for NATO Beneficiaries

TRICARE covers North Atlantic Treaty Organization (NATO) foreign nations' armed forces members who are stationed in the United States or are in the United States at the invitation of the U.S. government. They receive the same benefits as American ADSMs, including no out-of-pocket expenses for care if the care is directed by the Military Treatment Facility (MTF).

Eligible accompanying family members of ADSMs of NATO nations who are stationed in, or passing through, the United States in connection with their official duties can receive outpatient services under TRICARE Standard/TRICARE Extra. A copy of the family member's identification card will have a Foreign Identification Number or a Social Security Number (SSN) and indicate Outpatient Services Only.

NATO family members do not need MTF referrals prior to receiving outpatient services from civilian providers, follow the same prior authorization requirements as TRICARE Standard/TRICARE Extra beneficiaries and are responsible for TRICARE Standard cost-shares and deductibles.

To collect charges for services not covered by TRICARE, providers must have the NATO beneficiary agree, **in advance and in writing**, to accept financial responsibility for any noncovered service by signing the *TRICARE Noncovered Services Waiver* form. To download the form, search for **TRICARE Noncovered Services Waiver** at **Humana-Military.com**.

TRICARE does not cover inpatient services for NATO beneficiaries. To be reimbursed for inpatient services, the NATO beneficiary must make the appropriate arrangements with the NATO nation embassy or consulate in advance.

NATO beneficiary eligibility is maintained in the Defense Enrollment Eligibility Reporting System (DEERS). Claims submission procedures are the same as for American ADFMs.

## USFHP Designated Providers

Figure 8.4

| | | |
|---|---|---|
| **Brighton Marine Health Center**<br>P.O. Box 9195<br>Watertown, MA 02471-9195<br>1-800-818-8589 | **Johns Hopkins Medical Services Corporation**<br>6704 Curtis Court<br>Glen Burnie, MD 21060<br>1-800-808-7347 | **Pacific Medical Clinics**<br>US Family Health Plan<br>1200 12th Avenue South, Quarters 8 & 9<br>Seattle, WA 98144<br>1-888-958-7347 |
| **CHRISTUS Health**<br>US Family Health Plan<br>ATTN: Claims<br>P.O. Box 924708<br>Houston, TX 77292-4708<br>1-800-678-7347 | **Martin's Point Health Care**<br>P.O. Box 11410<br>Portland, ME 04104-5040<br>1-888-732-7364 | **St. Vincent Catholic Medical Centers of New York**<br>US Family Health Plan at SVCMC<br>P.O. Box 830745<br>Birmingham, AL 35283-0745<br>1-800-241-4848 |

## Claims for Beneficiaries Using Medicare and TRICARE

Wisconsin Physicians Service/TRICARE Dual Eligible Fiscal Intermediary Contract (WPS/TDEFIC) is the claims processor for all TFL claims. Providers who currently submit claims to Medicare on a patient's behalf do not need to submit a claim to WPS/TDEFIC. WPS/TDEFIC has signed agreements with each Medicare carrier allowing direct, electronic transfer of TRICARE beneficiary claims to WPS/TDEFIC. Beneficiaries and providers will receive EOBs from WPS/TDEFIC after processing.

**Note:** Participating providers accept Medicare's payment amount. Non-participating 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 non-participating providers may bill Medicare.

When TRICARE is the primary payer, all TRICARE requirements apply. Refer to the *TRICARE Reimbursement Manual*, Chapter 13 at **http://manuals.tricare.osd.mil**.

Figure 8.5 provides important contact information regarding Medicare and TRICARE claims.

## Medicare and TRICARE Claims Contact Information

Figure 8.5

| | |
|---|---|
| **Appeals** | WPS/TDEFIC<br>ATTN: Appeals<br>P.O. Box 7490<br>Madison, WI 53707-7490 |
| **Claims Submission**<br>(**Note:** Submit claims to Medicare first.) | WPS/TDEFIC<br>P.O. Box 7890<br>Madison, WI 53707-7890 |
| **Customer Service** | WPS/TDEFIC<br>P.O. Box 7889<br>Madison, WI 53707-7889 |
| **Online** | www.TRICARE4u.com |
| **Program Integrity** | WPS/TDEFIC<br>ATTN: Program Integrity<br>P.O. Box 7516<br>Madison, WI 53707-7516 |
| **Refunds** | WPS/TDEFIC<br>ATTN: Refunds<br>P.O. Box 7928<br>Madison, WI 53707-7928 |
| **Third-Party Liability** | WPS/TDEFIC<br>ATTN: TPL<br>P.O. Box 7897<br>Madison, WI 53707-7897 |
| **Toll-Free Telephone** | 1-866-773-0404 |
| **Toll-Free TDD** | 1-866-773-0405 |

## Claims for CHAMPVA

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is **not** a TRICARE program. For questions or general correspondence, contact CHAMPVA using the information listed in Figure 8.6.

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. 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

Providers may request a written appeal if exceptional circumstances prevented them 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 the appeal.

If a CHAMPVA claim is misdirected to PGBA, PGBA will forward it to the CHAMPVA Veterans Affairs (VA) Health Administration Center in Denver within 72 hours and will send a letter 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 VA Health Administration Center.

## CHAMPVA Contact Information

Figure 8.6

| | |
|---|---|
| **Phone** | 1-800-733-8387 |
| **Mail** | VA Health Administration Center<br>CHAMPVA<br>P.O. Box 469064<br>Denver, CO 80246-9064 |
| **Website** | www.va.gov/hac/forproviders |

## 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 to process all CHCBP claims. CHCBP beneficiaries may request providers file medical claims on their behalf. For questions and assistance regarding CHCBP claims, call PGBA at **1-800-403-3950**.

While PGBA is the South Region claims processor for TRICARE programs, CHCBP claims are filed to a different address within PGBA. Filing claims correctly ensures timely and accurate claims payment.

**Note:** Send claims for CHCBP beneficiaries with Medicare to PGBA, **not** to WPS/TDEFIC.

Providers can file CHCBP claims electronically at **www.myTRICARE.com** or file paper claims at one of the addresses listed in Figure 8.7.

## CHCBP Claims Addresses

Figure 8.7

| |
|---|
| **CHCBP Behavioral Health Claims:**<br>P.O. Box 7037<br>Camden, SC 29020-7037 |
| **All Other CHCBP Claims:**<br>P.O. Box 7031<br>Camden, SC 29020-7031 |

## Claims for the Extended Care Health Option

All claims for ECHO and the DoD Enhanced Access to Autism Services Demonstration must have a valid written authorization, and the beneficiary must show as enrolled in ECHO in DEERS.

All claims for ECHO-authorized care (including ECHO Home Health Care and the DoD Enhanced Access to Autism Services Demonstration) that have been authorized under ECHO must be billed on individual line items. Unauthorized ECHO care claims will be denied.

ECHO claims will be reimbursed for the amount negotiated, the Fiscal Year (FY) benefit limit or the TRICARE allowable charge, whichever is lower. Each line item on an ECHO claim must correspond to a line item on the service authorization, or the claim may be denied or delayed due to research and reconciliation.

The billed amount for procedures must reflect the service, not the applicable ECHO benefit limits. Pricing of ECHO services and items is determined in accordance with the *TRICARE Reimbursement Manual*.

Refer to the *TRICARE Policy Manual*, Chapter 9, Sections 4.1, 11.1, 14.1 and 18.1 at **http://manuals.tricare.osd.mil**.

## Claims for TRICARE Reserve Select and TRICARE Retired Reserve

All individuals covered under TRICARE Reserve Select (TRS) should follow the applicable cost-shares, deductibles and catastrophic caps for ADFMS covered under TRICARE Standard/TRICARE Extra.

All individuals covered under TRICARE Retired Reserve (TRR) should follow the applicable cost-shares, deductibles and catastrophic caps for retirees and eligible family members covered under TRICARE Standard/TRICARE Extra.

### TRICARE Network Providers

File claims with PGBA electronically on behalf of TRS and TRR beneficiaries in the same manner as filing other TRICARE claims.

The cost-share for all TRS beneficiaries, 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 beneficiaries, including National Guard and Reserve 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.

### Non-Network TRICARE-Authorized Providers

Participation with TRICARE (e.g., accepting assignment, filing claims and accepting the TRICARE allowable charge as payment in full) is encouraged, but not required, on TRS and TRR claims. Non-network providers are encouraged to submit their TRICARE claims electronically.

The cost-share for all TRS beneficiaries is 20 percent of the TRICARE allowable charge for covered services from participating non-network TRICARE-authorized providers. TRICARE will reimburse the remaining amount of the TRICARE allowable charge.

The cost-share for all TRR beneficiaries is 25 percent of the TRICARE allowable charge for covered services from participating non-network TRICARE-authorized providers. TRICARE will reimburse the remaining amount of the TRICARE allowable charge.

If a non-network provider does not participate on a particular claim, beneficiaries must file their own reimbursement claims with TRICARE and then pay the non-network provider.

**Note:** By federal law, if a non-network provider does not participate on a particular claim, the provider may not charge TRS/TRR beneficiaries more than 15 percent above the TRICARE allowable charge.

Visit **www.TRICARE.mil/CMAC** to find the fee schedules.

## Supplemental Health Care Program Claims

PGBA processes and pays claims for SHCP. Send all paper TRICARE claims to:

TRICARE South Region Claims Department
P.O. Box 7031
Camden, SC 29020-7031

The same balance-billing limitations applicable to TRICARE apply to SHCP. For more information, see *Balance Billing* in the *Important Provider Information* section.

# 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, required actions can affect total processing time.

Inpatient claims submitted with diagnosis codes 800 to 999 (with some exclusions, as listed in Figure 8.8), regardless of the billed amount, and outpatient professional claims that exceed a TRICARE liability of $500, which indicate an accident, injury or illness, will be pended 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*).

Certain diagnosis codes are exceptions. A *DD Form 2527* is not required for the codes listed in Figure 8.8.

## Diagnosis Codes Exceptions/Exclusions

Figure 8.8

| ICD-9 Codes for Dates of Service before October 1, 2014 | ICD-10 Codes for Dates of Service on or after October 1, 2014 |
|---|---|
| 910.2–910.7 | S00.02, S00.05, S00.06, S00.32, S00.35, S00.36, S00.42, S00.45, S00.46, S00.52, S00.551, S00.56, S00.82, S00.85, S00.86, S00.92, S00.95, S00.96, S10.12, S10.15, S10.16, S10.82, S10.85, S10.86, S10.92, S10.95, S10.96 |
| 911.2–911.7 | S20.12, S20.15, S20.16, S20.32, S20.5, S20.36, S20.42, S20.45, S20.46, S20.92, S20.95, S20.96, S30.82, S30.85, S30.86 |
| 912.2–912.7 | S40.22, S40.25, S40.26, S40.82, S40.85, S40.86 |
| 913.2–913.7 | S50.32, S50.35, S50.36, S50.82, S50.85, S50.86 |
| 914.2–914.7 | S60.52, S60.55, S60.56, S60.82, S60.85, S60.86 |
| 915.2–915.7 | S60.32, S60.35, S60.36, S60.42, S60.45, S60.46 |
| 916.2–916.7 | S70.22, S70.25, S70.26, S70.32, S70.35, S70.36, S80.22, S80.25, S80.26, S80.82, S80.85, S80.86 |
| 917.2–917.7 | S90.42, S90.45, S90.46, S90.52, S90.55, S90.56, S90.82, S90.85, S90.86 |
| 918.0 | S00.2 |
| 918.2 | S05.0 |
| 919.2–919.7 | T07, T14 |

When a received claim appears to have possible third-party involvement, the following process will occur:

1. A copy of *DD Form 2527* will be mailed to the beneficiary.
2. The claim is pended for up to 35 calendar days. If *DD Form 2527* is not received within that time period, the claim will be denied.
3. The claim will be reprocessed when *DD Form 2527* is completed and returned by the beneficiary. (Encourage the beneficiary to fill out the form within the 35 calendar days to avoid payment delays.)
4. If the illness or injury was not caused by a third party, the beneficiary is still responsible for completing the *DD Form 2527* when the ICD-9-CM diagnosis falls between 800 and 999 or the ICD-10-CM diagnosis code(s) falls between S00.00 and T88.9 with a seventh character of A, B or C (indicating initial encounters). If the form is not returned, the claim will be denied, and the provider may bill the beneficiary.

# TRICARE and Other Health Insurance

TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service and other programs or plans as identified by TMA. TRICARE beneficiaries who have OHI do not need referrals or prior authorizations for covered services except for those services listed in Figure 8.9, which require prior authorization even when OHI coverage exists.

## OHI: Services Requiring TRICARE Prior Authorization

Figure 8.9

- Adjunctive dental care
- Behavioral health care services
  - All nonemergency inpatient admissions for substance use disorder or behavioral health care services
  - Partial Hospitalization Programs (PHPs) and residential treatment center (RTC) programs
  - Psychoanalysis
  - Outpatient visits exceeding eight visits in a Fiscal Year (October 1 to September 30)
- Extended Care Health Option (ECHO) services
- Home health services
- Hospice services
- Solid organ and stem-cell transplants

If the OHI benefits are exhausted, TRICARE becomes the primary payer, and additional referral/prior authorization requirements may apply. Since OHI status can change at any time, always ask all beneficiaries about OHI, including National Guard and Reserve members and their families.

If a beneficiary's OHI status changes, update patient billing system records to avoid delays in claim payments. If a provider indicates that there is no OHI, but Humana Military's files indicate otherwise, a signed or verbal notice from the beneficiary will be required to inactivate the OHI record.

When a TRICARE-eligible beneficiary has OHI, submit a claim using the guidelines found in Figure 8.10.

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.

## OHI Claims Guidelines — Figure 8.10

| | |
|---|---|
| **Identify OHI in the Claim Form** | To identify OHI in the claim form:<br>• Mark Yes in Box 11d (CMS-1500) or FL 34 (UB-04).<br>• Indicate the primary payer in Box 9 (CMS-1500) or FL 50 (UB-04).<br>• Indicate the amount paid by the other carrier in Box 29 (CMS-1500) or FL 54 (UB-04).<br>• Indicate insured's name in Box 4 (CMS-1500) or FL 58 (UB-04).<br>• Indicate the allowed amount of the OHI in FL 39 (UB-04) using value code 44 and entering the dollar amount. |
| **Payment Guidelines** | If TRICARE is the secondary payer, submit the claim to the primary payer first. If the claim processor's records indicate that the beneficiary has one or more primary insurance policies, submit EOB information from other insurers along with the TRICARE claim.<br><br>Humana Military will coordinate benefits when a claim has all necessary information (e.g., billed charges, beneficiary's copay and OHI payment). In order for Humana Military to coordinate benefits, the EOB must reflect the patient's liability (copay 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 use network providers, TRICARE will also deny the claim.<br><br>TRICARE does not always pay the beneficiary's copay 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.<br><br>With TRICARE network providers and non-network providers that accept TRICARE assignment, TRICARE pays the lesser of:<br>• The billed amount minus the OHI payment<br>• The amount TRICARE would have paid without OHI<br>• The beneficiary's liability (OHI copay, cost-share, deductible, etc.)<br><br>With non-network providers that do not accept TRICARE assignment, providers 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, then no TRICARE payment is authorized, the charge is considered paid in full and the provider may not bill the beneficiary. If the service is considered noncovered by TRICARE, the beneficiary may be liable for these charges.<br><br>With all other providers, TRICARE pays the lesser of:<br>• 115 percent of the allowed amount minus the OHI payment<br>• The amount TRICARE would have paid without OHI<br>• The beneficiary's liability (OHI copay, cost-share, deductible, etc.)<br><br>When working with OHI, all TRICARE providers should keep in mind:<br>• TRICARE will not pay more as a secondary payer than it would as a primary payer.<br>• Point-Of-Service (POS) cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. However, the beneficiary must have prior authorization for certain covered services (listed in Figure 8.9), regardless of whether he or she has OHI. |

# 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. Before sending a beneficiary's claim to a collection agency, providers should do one or more of the following:

- Submit an administrative review request to PGBA.
- Request an adjustment on an allowable charge review from PGBA.

Please wait at least 45 days after submitting a claim before contacting Humana Military. Beneficiaries are responsible for their out-of-pocket expenses, unless the outstanding amount is the beneficiary's deductible, cost-share or copay amount reflected on the provider remittance advice.

# TRICARE's Debt Collection Assistance Officer Program

Debt Collection Assistance Officers (DCAOs) are located at TRICARE Regional Offices and MTFs to assist TRICARE beneficiaries in determining the validity of collection agent claims and/or negative credit reports received for debts incurred as a result of receiving health care under the TRICARE program. ("Health care" includes medical and adjunctive dental care under TRICARE.)

DCAOs 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 debt-inducing circumstances. The DCAO directory is available online at **www.TRICARE.mil/BCACDCAO**.

Beneficiaries must take or submit documentation associated with a collection action or adverse credit rating to the DCAO (e.g., debt collection letters, TRICARE EOBs and health care bills from providers). The more information the beneficiary provides, the less time it will take to determine the cause of the 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 Claims Auditing

The TRICARE South Region uses a claims auditing tool to review prepayment basis. This auditing tool is an automated clinical tool that contains specific auditing logic designed to evaluate provider billing for CPT coding appropriateness and to eliminate overpayment on professional and outpatient hospital service claims. Humana Military updates the claims auditing tool periodically with new coding based on current industry standards.

## Edits

Follow CPT coding guidelines to prevent claims auditing editing from resulting in claim denials. Claims auditing edits will be explained by a message code on the remittance advice.

The auditing tool also includes, but is not limited to, the following edit categories:

- Age conflicts
- Alternate code replacements
- Assistant surgeon requirements
- Cosmetic procedures
- Duplicate and bilateral procedures
- Duplicate services
- Gender conflicts
- Incidental procedures
- Modifier auditing
- Mutually exclusive procedures
- Preoperative and postoperative auditing billed
- Procedure unbundling
- Unlisted procedures

The complete set of code edits is proprietary and, as such, cannot be released to the general public.

Providers are not permitted to bill TRICARE beneficiaries for services rejected by claims auditing. For questions regarding this editing function, contact PGBA at 1**-800-403-3950**.

## Review of Provider Claims

Humana Military checks claims for consistency, intensity of service and revisit frequency through the codes specified. To avoid unnecessary claim line rejections, assign a diagnosis code that represents the reason the service or procedure is performed, as well as any diagnoses that will impact treatment.

## Claims Reconsiderations

Participating providers may have claims reconsidered through medical review for issues including:

- Requests for verification that the edit was appropriately entered for the claim
- Situations in which the provider submits additional documentation substantiating that unusual circumstances existed

If a line on a claim is rejected, first review the medical documentation for any additional diagnosis and, if found, submit it on a corrected claim. If other diagnoses are not found after review, providers may request a reconsideration.

Providers should include the *Reconsideration Coversheet* with their

request. Download a copy from **Humana-Military.com** by searching for **Reconsideration**.

Send supporting medical record information to:

TRICARE South Correspondence
P.O. Box 7032
Camden, SC 29020-7032

# Prepayment Review

Prepayment review of **medical necessity** or appropriate level of care is available from Humana Military upon written request. Providers may request reconsideration of a review within 90 days of the initial claim determination by PGBA. Please mail requests to:

TRICARE South Region
Appeals Department
P.O. Box 202002
Florence, SC 29502-2002

# TRICARE Claim Appeals

In the event that a provider disagrees with payment, TRICARE has a claim appeals process to review claims. There are a few different types of claim appeals:

- **Network provider claim appeals:** Network providers who are dissatisfied with claim denial can appeal under the administrative review process. The process for administrative review and general claim appeals are similar and require the same information.
- **Non-network provider and beneficiary claim appeals:** Non-network participating providers (i.e., those that accept assignment) and beneficiaries can appeal a TRICARE claim.
- **Claim adjustments:** Providers or beneficiaries can request allowable charge reviews if they disagree with the reimbursement allowed on a claim. This includes appeals for "By Report" or unlisted procedures where a provider can request an appeal.

Following are details about the appropriate types of appeal requests, timeframes for submitting an appeal request, addresses and the information to include with the request. By following the rules and timelines for requesting reviews, providers can help promptly resolve requests.

After a request is submitted, Humana Military will notify the provider in writing or by telephone of the outcome.

## Section 1869/1878 Social Security Act—Appeals Determination

There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.

## Claims Adjustments and Allowable Charge Reviews

A provider or a beneficiary can request an allowable charge review if either party disagrees with the reimbursement allowed on a claim. This includes "By Report" or unlisted procedures where a provider can request a review.

The following issues are considered reviewable:

- Allowable charge complaints
- Charges denied as "Included in a paid service"
- Keying errors/corrected bills
- Eligibility denials/patient not in DEERS
- Cost-share and deductible inquiries/disputes
- Claims denied because the provider is not a TRICARE-authorized provider
- Claims auditing tool denials (except assistant surgeons)
- OHI denials/issues
- Prescription drug coverage
- TPL denials/issues
- Claims denied or payments reduced due to lack of authorization
- POS when reason for dispute is other than emergency care
- Claims denied due to late filing
- Charges denied as a duplicate charge
- Claims denied as "Requested information was not received"
- Coding issues
- Claims denied because Nonavailability Statement (NAS) is not in DEERS
- Network provider disputes relating to contractual reimbursement amount

If requesting an allowable charge review, providers must submit the following information:

- A copy of the claim and the TRICARE EOB or TRICARE Summary Payment Voucher/Remit
- Supporting medical records and any new information not originally submitted with the claim

**Note:** Requests must be postmarked or received **within 90 calendar days** of the date of the TRICARE EOB.

Send all requests to:

TRICARE South Region Customer Service Department
P.O. Box 7032
Camden, SC 29020-7032

## Appeals and Administrative Reviews of Claims Denials

The following are considered appealable issues:

- Claims denied because the service is not covered under TRICARE or exceeds policy limitations/coverage criteria
- Claims denied as not medically necessary
- Claims for assistant surgeon charges denied by the claims auditing tool
- 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 noncovered 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 may have further appeal rights.

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.

Please mail requests to:

TRICARE South Region
Appeals Department
P.O. Box 202002
Florence, SC 29502-2002

After a request is submitted, Humana Military will notify the provider in writing or by telephone of the outcome.

When filing appeals, keep in mind the following:

- All appeal and administrative review requests must be in writing and signed by the appealing party or the appealing party's representative.
- All appeal and 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.
- If submitting supporting documentation, the timely filing of the appeal should not be delayed while gathering the documentation.
- If intending to obtain supporting documentation that is not readily available, file the appeal and state in the appeal letter the intention to submit additional documentation and the estimated date of submission.
- Providers must meet the 90-day filing deadline, or the request for reconsideration will generally not be accepted.

In addition, include the following information with an appeal:

- Sponsor's SSN or patient's DBN
- Beneficiary's/patient's name
- Date(s) of service
- Provider's address, telephone/fax numbers and email address, if available
- Statement of the facts of the request

Appeals must be requested by an appropriate appealing party. Persons or providers who may appeal are limited to:

- TRICARE beneficiaries (including minors)
- Participating non-network TRICARE-authorized providers
- A custodial parent or guardian of a minor beneficiary
- A provider denied approval as a TRICARE-authorized provider
- A provider who has been terminated, excluded or suspended
- A representative appointed by a proper appealing party. Examples of representatives are:
    - Parents of a minor (If the patient is a minor, his or her custodial parent is presumed to have been appointed his or her representative in the appeal.)
    - An attorney
    - A network provider

Administrative reviews must be requested by the network provider.

# TRICARE Reimbursement Methodologies

Reimbursement rates and methodologies are subject to change per Department of Defense (DoD) guidelines. For more information, refer to the *TRICARE Reimbursement Manual* at **http://manuals.tricare.osd.mil**.

## Reimbursement Limitations

Payments made to network and non-network providers for medical services rendered to beneficiaries shall not exceed 100 percent of the TRICARE allowable charge for the services. Visit **www.TRICARE.mil/CMAC** to find the TRICARE allowable charges.

The TRICARE allowable charge is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. For non-network providers, TRICARE will reimburse the lesser of the TRICARE allowable charge or the provider's billed charge for the service.

Figure 9.1 lists TRICARE provider categories.

## TRICARE Provider Categories

Figure 9.1

| Category | Provider Type | Facility Type |
|---|---|---|
| Category 1 | Medical Doctors (MDs), Doctors of Osteopathic Medicine (DOs), optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, audiologists, Certified Nurse Midwives (CNMs) and applicable outpatient hospital services (See Chapter 5 of the TRICARE Reimbursement Manual.) | Services provided in a facility[1] |
| Category 2 | MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, audiologists, CNMs and applicable outpatient hospital services | Services provided in a nonfacility[2] |
| Category 3 | All provider types not found in Category 1 | Facility setting |
| Category 4 | All provider types not found in Category 2 | Nonfacility setting |

*1. A facility includes the following: ambulances, Ambulatory Surgery Centers (ASCs), community mental health centers, hospices, hospitals (both inpatient and outpatient where the hospital generates a revenue bill; i.e., revenue code 510), Military Treatment Facilities (MTFs), psychiatric facilities, Residential Treatment Centers (RTCs) and Skilled Nursing Facilities (SNFs).*

*2. A nonfacility includes the following: home settings, provider offices and other nonfacility settings.*

## State-Prevailing Rates

State-prevailing rates are established for codes that have no current available TRICARE allowable charge 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 fee schedule 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 nonspecialty basis

For the latest details concerning prevailing rates, see the *TRICARE Reimbursement Manual*, Chapter 5, Section 13 at **http://manuals.tricare.osd.mil**.

For example:

- If the TRICARE allowable charge for a service from a non-network provider is $90 and the billed charge is $50, TRICARE will allow $50 (the lower of the two charges).
- If the TRICARE allowable charge for a service from a non-network provider is $90, and the billed charge is $100, TRICARE will allow $90 (the lower of the two charges).

In the case of inpatient hospital services from a non-network provider, the specific hospital reimbursement method applies. For example, the Diagnosis-Related Group (DRG) rate is the TRICARE allowable charge for inpatient hospital services.

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.

Non-network nonparticipating providers have the legal right to charge beneficiaries up to 115 percent of the TRICARE allowable charge for services.

# Anesthesia Claims and Reimbursement

Professional anesthesia claims must be submitted using the Current Procedural Terminology (CPT®) anesthesia codes. If applicable, the claim must also be billed with the appropriate physical-status modifier and, if needed, 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 non-physician anesthetist performs the remainder, the claim must identify exactly which services were provided by each type of provider. This distinction may be made by the use of modifiers.

## Calculating Anesthesia Reimbursement Rates

TRICARE calculates anesthesia reimbursement rates using the number of time units, the Medicare Relative Value Units (RVUs) and the anesthesia conversion factor.

The following formula is used to calculate the TRICARE anesthesia reimbursement:

(Time Units + RVUs)
×
Conversion Factor

**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 the anesthesia care
- Interpretation of noninvasive monitoring (e.g., electrocardiogram, temperature, blood pressure, oximetry, capnography and mass spectrometry)
- Determination of the required dosage/method of anesthesia
- Induction of anesthesia
- Follow-up care for possible postoperative effects of anesthesia on the beneficiary

Services **not** included in the base unit 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 postanesthesia supervision. Providers must indicate the number of time units in column 24G of the CMS-1500 form.

**Conversion Factor:** The sum of the time units and RVUs is multiplied by a conversion factor. Conversion factors differ between physician and non-physician providers and vary by state, based on local wage indexes.

For more specific information on anesthesia reimbursement calculation and methodologies, refer to the *TRICARE Reimbursement Manual* at **http://manuals.tricare.osd.mil**.

## Anesthesia Procedure Pricing Calculator

For an anesthesia rate calculator, go to **www.TRICARE.mil/anesthesia** 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.

Ambulatory surgery facility payments fall into one of 11 TRICARE grouper rates. All procedures identified by the TRICARE Management Activity (TMA) for reimbursement under this methodology can be found at **http://manuals.tricare.osd.mil**. 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 by visiting **www.TRICARE.mil/ambulatory**.

## 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.

# Diagnosis-Related Group Reimbursement

DRG reimbursement is a reimbursement system for inpatient charges from facilities. This system assigns payment levels to each DRG based on the average cost of treating all TRICARE beneficiaries in a given DRG.

The TRICARE DRG-based payment system is modeled on the Medicare inpatient Prospective Payment System (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. For more details, see the *TRICARE Reimbursement Manual* at **http://manuals.tricare.osd.mil**.

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 paid under the TRICARE DRG-based payment system are required to report a Present-On-Admission (POA) indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. POA is defined as present at the time the order for inpatient admission occurs.

Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered POA. Any hospital-acquired conditions, as identified by Medicare, will not be reimbursed. A list of hospital-acquired conditions can be found at **www.TRICARE.mil/DRGrates**.

Any claim that does not report a valid POA indicator for each diagnosis on the claim will be denied. Figure 9.2 describes the five valid POA codes.

### POA Code Descriptions Figure 9.2

| 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, that 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 that the documentation is insufficient to determine whether the condition was present at the time of admission. |
| 1 | Prior to Fiscal Year (FY) 2011, signified exemption from POA reporting. The Centers for Medicare & Medicaid Services (CMS) established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines. This exemption to POA reporting is not available for reporting on the electronic 5010.<br><br>As of FY 2011, signifies unreported/not used. Exempt from POA reporting. (This code is equivalent to a blank on the CMS 1450 UB-04; however, it was determined that blanks are undesirable when submitting this data via 4010A.) |

The following hospitals are exempt from POA reporting for TRICARE:

- Critical Access Hospitals (CAHs)
- Long-term care hospitals
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient hospitals
- Inpatient rehabilitation hospitals
- Psychiatric hospitals and psychiatric units
- Sole community hospitals
- U.S. Department of Veterans Affairs (VA) hospitals

## Diagnosis-Related Group Calculator

The DRG calculator is available at **www.TRICARE.mil/DRGrates**.

Providers can locate the Indirect Medical Education (IDME) factor (for teaching hospitals only) and wage index information using the Wage Indexes and IDME Factors File that are also available on the DRG Web page. If a hospital is not listed in the Wage Indexes and IDME Factors File, use the ZIP to Wage Index File to obtain the wage index for that area by ZIP code.

## Capital and Direct Medical Education Cost Reimbursement

Facilities may request capital and direct medical education cost reimbursement. Capital items, such as property, structures and equipment, usually cost more than $500 and can depreciate under tax laws. Direct medical education is defined as formally organized or planned programs of study in which providers engage to enhance the quality of care at an institution.

Submit reimbursement requests for capital and direct medical education costs to Humana Military and PGBA, Humana Military's claims processor, on or before the last day of the 12th month following the close of the hospital's cost-reporting period. The request should cover the one-year period corresponding with 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 include 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 (ADSMs) in units subject to DRG-based payment
- Total allowable capital costs (must correspond with the applicable pages from the Medicare cost report)

- Total allowable direct medical education costs (must correspond with the applicable pages from the Medicare cost report)
- Total full-time equivalents for residents and interns
- Total inpatient beds as of the end of the cost-reporting period
- Title of official signing the report
- Reporting date

The submission must include a statement certifying that any changes, if applicable, were made as a result of a review, audit or appeal of the provider's Medicare cost report. Report any changes to Humana Military and PGBA within 30 days of the date the hospital is notified of the change. In addition, the provider's officer or administrator must certify all cost reports.

# Bonus Payments in Health Professional Shortage Areas

Network and non-network physicians — MDs, DOs, podiatrists, oral surgeons and optometrists — who qualify for Medicare bonus payments in Health Professional Shortage Areas (HPSAs) may be eligible for a 10 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, psychiatric nurse practitioners and marriage therapists) are not eligible.

Providers can determine if they are in an HPSA using the U.S. Department of Health and Human Services Health Resources and Services Administration's HPSA search tool at **http://hpsafind.hrsa.gov**. The Centers for Medicare and Medicaid Services (CMS) provides HPSA designations along with bonus payment information at **www.CMS.HHS.gov/HPSAPSAPhysicianBonuses**.

## How Bonus Payments Are Calculated

For providers who are eligible and located in an HPSA, PGBA will calculate a quarterly 10 percent bonus payment from the total paid amount for TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TRICARE Standard/TRICARE Extra, TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) claims and the amount paid by the government on Other Health Insurance (OHI) claims.

Please keep in mind the following:

- When submitting a claim for the bonus payment, providers **must** include the AQ CPT modifier in Box 24D of the CMS-1500 claim form.
- For CPT codes with multiple modifiers, place the AQ modifier last.
- If providers are eligible for a bonus payment but do not submit claims with the appropriate modifier, they will not receive the bonus payment from TRICARE. There are no retroactive payments, adjustments or appeals for obtaining a bonus payment, so include the bonus payment modifier with initial claims submission if eligible.
- When calculating bonus payment for services containing 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. Providers who submit claims without the modifier cannot receive a bonus payment.

# Skilled Nursing Facility Pricing

TRICARE pays Skilled Nursing Facilities (SNFs) using the Medicare PPS and consolidated billing. SNF PPS rates cover all routine, ancillary and capital costs of covered SNF services.

SNFs are required to perform resident assessments using the Minimum Data Set. SNF admissions require authorizations when TRICARE is the primary payer.

SNF admissions for children under age 10 and CAH swing beds are exempt from SNF PPS and are reimbursed based on DRG or contracted rates.

For information about SNF PPS, refer to the *TRICARE Reimbursement Manual*, Chapter 8, Section 2 at **http://manuals.tricare.osd.mil**.

# Home Health Agency Pricing

TRICARE pays Medicare-certified Home Health Agencies (HHAs) using a PPS modeled on Medicare's plan. Medicare-certified billing is handled in 60-day 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 Humana Military 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

When filing a Request for Anticipated Payment (RAP), keep in mind the following:

- 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 residence 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 treatment authorization code assigned by the Outcome Assessment Information Set. **Note:** This is **not** Humana Military's prior authorization number.

### 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 RAP.
- 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 these 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*, Chapter 8, Section 15.1 at **http://manuals.tricare.osd.mil**.

## Durable Medical Equipment, Prosthetics, Orthotics and Supplies Pricing

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) prices are established by using the Medicare fee schedules, reasonable charges or state-prevailing rates. Most Durable Medical Equipment (DME) payments are based on the fee schedule established for each DMEPOS item by state. The services and/or supplies are coded using CMS Healthcare Common Procedure Coding System (HCPCS) Level II codes that begin with the following letters:

- A (medical and surgical supplies)
- B (enteral and parenteral therapy)
- E (DME)
- K (temporary codes)
- L (orthotics and prosthetic procedures)
- V (vision services and hearing aids)

Inclusion or exclusion of a fee schedule amount for an item or service does **not** imply TRICARE coverage or noncoverage.

Use the following modifiers to identify repair and replacement of an item.

- RA (replacement of an item): The RA modifier on claims denotes instances where an item is furnished as a replacement for the same item that has been lost, stolen or irreparably damaged.
- RB (replacement of a part of DME furnished as part of a repair): The RB modifier indicates replacement parts of an item furnished as part of the service of repairing the item.

DMEPOS pricing information is available at **www.TRICARE.mil/DMEPOS**.

## 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 DME. DME verification is not required.

Home infusion drugs are reimbursed according to TRICARE policy. These drugs must be billed using an appropriate HCPCS code along with a specific National Drug Code (NDC) for pricing.

Claims for home infusion will be identified by the place of service and the CMS HCPCS National Level II Medicare codes, along with the specific NDC number, drug units and quantity 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.

Providers may use modifiers 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 has been increased or reduced.
- Only part of a service, an adjunctive service or a bilateral service was performed.
- A service or procedure was provided more than once.
- Unusual events occurred during the service.
- A procedure was terminated prior to completion.

Providers should use applicable modifiers that fit the description of the service, and the claim will be processed accordingly. The 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 CNM 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 (e.g., PA office visit) and use the PA's provider number. The supervising or employing physician of a PA must be a TRICARE-authorized provider.
- Supervising authorized providers that employ NPs may bill as noted for the PA, or the NP may bill on his or her own behalf and use his or her NP provider number for procedures or services performed.

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 that the assistant surgeon provided services in a facility without a teaching program.
- Modifier 81 is used for Minimum Assistant Surgeon when the services are only required for a short period during the procedure.
- Modifier 82 is used by the assistant surgeon when a qualified resident surgeon is not available.
- Modifier AS is used to designate an assistant at surgery.

**Note:** Modifiers 80 and 81 are applicable modifiers to use; however, PGBA will most likely wait for medical review to validate the medical necessity for surgical assistance, and medical records may be requested. During this process, the claim also will be reviewed to validate that the facility has (or does not have) residents and interns on staff (e.g., small community hospitals).

# Surgeon's Services for Multiple Surgeries

Multiple surgical procedures have specific reimbursement requirements. When multiple surgical procedures are performed, the primary surgical procedure (i.e., the surgical procedure with the highest allowable rate) will be paid at 100 percent of the contracted rate. Any additional covered procedures performed during the same surgical 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 little additional physician resources and/or is clinically integral to the performance of the primary procedure. Payment for the incidental procedure is considered to be included in the payment of the primary procedure.

Certain codes are considered add-ons or modifier 51 exempt. Procedures for non-OPPS professional and facility claims should not apply a reduction as a secondary procedure.

# Outpatient Prospective Payment System

TRICARE OPPS is mandatory for both network and non-network providers and applies to all hospitals participating in the Medicare program with some exceptions (e.g., CAHs, cancer hospitals 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:

- CAHs
- 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
    - VA hospitals
    - Freestanding ASCs

- Freestanding birthing centers
- Freestanding end-stage renal disease facilities
- Freestanding PHPs (psychiatric facilities and Substance Use Disorder Rehabilitation Facilities [SUDRFs])
- HHAs
- Hospice programs
- Other corporate services providers (e.g., freestanding cardiac catheterization and sleep disorder diagnostic centers)
- SNFs
- Residential Treatment Centers (RTCs)

TRICARE allowable charge /CMAC fee schedule pricing, including injectable rates on payable claim lines not grouped to an APC, are updated on a quarterly basis. Annual TRICARE allowable charge /CMAC rates generally available and effective February 1 have a two-month lag under OPPS (i.e., April 1 instead of February 1).

For more information on TRICARE OPPS implementation, refer to the *TRICARE Reimbursement Manual*, Chapter 13 at **http://manuals.tricare.osd.mil** or visit **www.TRICARE.mil/OPPS**.

## 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 to 609 and 613 to 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 9.3 shows the TTPA percentages for APC codes 604 to 609 and 613 to 616 during the four-year network hospital and three-year non-network hospital transition periods.

## Temporary Military Contingency Payment Adjustments

Network hospitals that have received OPPS payments of $1.5 million or more for care provided to ADSMs and Active Duty Family Members (ADFMs) during an OPPS year (May 1 through April 30) will be given a Temporary Military Contingency Payment Adjustment (TMCPA). Hospitals that qualified for a TMCPA received a 20 percent increase in the total OPPS payments for the initial year of OPPS (May 1, 2009 through April 30, 2010). Subsequent adjustments have been reduced by 5 percent each year until the OPPS payment levels are reached in year five (i.e., 15 percent in year two, 10 percent in year three and 5 percent in year four).

## Filing Claims for PHP Charges

The TRICARE OPPS pays claims filed for hospital outpatient services, including hospital-based PHPs (psychiatric and SUDRFs) subject to TRICARE's prior authorization requirements. The outpatient code editor logic requires that hospital-based PHPs provide a minimum of three units of service per day in order to receive PHP payment.

TRICARE has adopted Medicare's PHP reimbursement methodology for hospital-based PHPs. There are two separate APC payment rates under this reimbursement methodology:

- APC 0172: For days with three services
- APC 0173: For days with four or more services

In addition, TRICARE allows physicians, clinical psychologists, clinical nurse specialists, NPs and PAs to bill separately for their professional services delivered in a PHP. The only professional services included in the PHP per diem payment are those furnished by clinical social workers, occupational therapists, and alcohol and addiction counselors.

The claim must include a behavioral health diagnosis and an authorization on file for each day of service. Since there is no HCPCS code that specifies a partial hospitalization-related service, partial hospitalizations are identified by a particular bill type and condition code.

For more information about how OPPS affects TRICARE PHPs and for a complete listing of applicable revenue and HCPCS codes, refer to the *TRICARE Reimbursement Manual*, Chapter 13, Section 2 at **http://manuals.tricare.osd.mil**.

## TTPA Percentages for APC Codes 604 to 609 and 613 to 616

Figure 9.3

| Transition Period | Network[1] | | Non-Network[2] | |
|---|---|---|---|---|
| | ER | Hospital Clinic | ER | Hospital Clinic |
| **Year 1** | 200% | 175% | 140% | 140% |
| **Year 2** | 175% | 150% | 125% | 125% |
| **Year 3** | 150% | 130% | 110% | 110% |
| **Year 4** | 130% | 115% | 100% | 100% |
| **Year 5** | 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 (i.e., 100 percent).*

*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 (i.e., 100 percent).*

## 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 the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice.

The only amounts that will be allowed outside of the locally adjusted national payment rates and not considered hospice services will be for direct patient-care services rendered by either an independent attending physician or a physician under contract with the hospice program.

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 claim form using the appropriate revenue code of 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 claim form using the appropriate CPT codes. These services will be subject to standard TRICARE reimbursement and cost-sharing/deductible provisions, and will not be included in the cap amount calculations.

The hospice will be reimbursed for the amount applicable to the type and intensity of the services furnished to the beneficiary on a particular day. One rate will be paid for each level of care, except for continuous home care, which will be reimbursed based on the number of hours of continuous care furnished to the beneficiary on a given day.

Reimbursement may be extended for routine and continuous hospice care provided to beneficiaries residing in nursing home facilities (i.e., that is, physician, nurse, social worker and home health aide visits to patients requiring palliative care for terminal illnesses). TRICARE will not pay for the room and board charges of the nursing home.

**Note:** Continuous home care must be equal to or greater than eight hours per day (midnight to midnight), and more than half of the care must be provided by either a registered or licensed practical nurse. The rates will be adjusted for regional differences using appropriate Medicare area wage indexes.

## Updates to TRICARE Rates and Weights

Reimbursement rates and methodologies are subject to change per DoD guidelines. TRICARE rates are subject to change on at least an annual basis. Rate changes are usually effective on the dates listed in Figure 9.4.

## TRICARE Rates Update Schedule

Figure 9.4

| Update Frequency | Rates Scheduled to Change |
|---|---|
| **Variable at TMA's discretion** | TRICARE allowable charge, also known as the CHAMPUS Maximum Allowable Charge (CMAC) (Allowable profiles are typically updated at least once per year, usually in the first quarter of the year.)<br>Anesthesia<br>Injectables and immunizations |
| **April 1** | Birthing centers |
| **October 1** | Diagnosis-Related Group (DRG)<br>Residential Treatment Center (RTC)<br>Behavioral health per diem<br>Skilled Nursing Facility (SNF) Prospective Payment System (may be adjusted quarterly)<br>Inpatient hospital copays and cost-shares<br>Hospice |
| **November 1** | Ambulatory surgery grouper |
| **December 1** | Critical Access Hospital (CAH) |
| **Quarterly (January, April, July, October)** | Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)<br>Home Health Prospective Payment System (PPS)<br>Outpatient Prospective Payment System (OPPS) |

The DoD has adjusted the TRICARE reimbursement rates to mirror Medicare's levels. Updated rates and weights are available at **www.TRICARE.mil/TMA/rates.aspx**.

# Provider Tools

## Acronyms

| | |
|---|---|
| ABA | Applied Behavior Analysis |
| ADDP | Active Duty Dental Program |
| ADFM | Active Duty Family Member |
| ADSM | Active Duty Service Member |
| CAC | Common Access Card |
| CCTP | Custodial Care Transition Program |
| CHAMPUS | Civilian Health and Medical Program of the Uniformed Services |
| CHAMPVA | Civilian Health and Medical Program of the Department of Veterans Affairs |
| CHCBP | Continued Health Care Benefit Program |
| CMAC | CHAMPUS Maximum Allowable Charge |
| DCAO | Debt Collection Assistance Officer |
| DEERS | Defense Enrollment Eligibility Reporting System |
| DoD | Department of Defense |
| DTF | Dental Treatment Facility |
| ECHO | Extended Care Health Option |
| EFMP | Exceptional Family Member Program |
| EHHC | ECHO Home Health Care |
| FY | Fiscal Year |
| HPSA | Health Professional Shortage Area |
| IVR | Interactive Voice Response |
| LOD | Line Of Duty |
| MHS | Military Health System |
| MMSO | Military Medical Support Office |
| MTF | Military Treatment Facility |
| NAS | Nonavailability Statement |
| NPI | National Provider Identifier |
| NPPES | National Plan and Provider Enumeration System |
| OPPS | Outpatient Prospective Payment System |
| PCM | Primary Care Manager |
| PHP | Partial Hospitalization Program |
| POS | Point Of Service |
| PRAF | Patient Referral Authorization Form |
| PSA | Prime Service Area |
| RTC | Residential Treatment Center |
| SUDRF | Substance Use Disorder Rehabilitation Facility |
| SHCP | Supplemental Health Care Program |
| SPOC | Service Point Of Contact |
| TAMP | Transitional Assistance Management Program |
| TCSRC | Transitional Care for Service-Related Conditions |
| TDP | TRICARE Dental Program |
| TFL | TRICARE For Life |
| TMA | TRICARE Management Activity |
| TMCPA | Temporary Military Contingency Payment Adjustment |
| TOP | TRICARE Overseas Program |
| TPR | TRICARE Prime Remote |
| TPRADFM | TRICARE Prime Remote for Active Duty Family Members |
| TQMC | TRICARE Quality Monitoring Contractor |
| TRDP | TRICARE Retiree Dental Program |
| TRIAP | TRICARE Assistance Program |
| TRR | TRICARE Retired Reserve |
| TRS | TRICARE Reserve Select |
| TSC | TRICARE Service Center |
| TTPA | Temporary Transitional Payment Adjustment |
| TYA | TRICARE Young Adult |
| USFHP | US Family Health Plan |
| USPHS | U.S. Public Health Service |
| VA | Department of Veterans Affairs |
| VAMC | VA Medical Center |
| WNAP | Warrior Navigation and Assistance Program |

# Glossary of Terms

**Accepting Assignment**
Those instances when a provider agrees to accept the TRICARE allowable charge.

**Authorization for Care**
The determination that the requested treatment is medically necessary, delivered in the appropriate setting, a TRICARE benefit and that the treatment will be cost-shared by the Department of Defense.

**Base Realignment and Closure Commission (BRAC) Site**
A military base that has been closed or targeted for closure by the government BRAC.

**Beneficiary**
A person who is eligible for TRICARE benefits. Beneficiaries include ADFMs and retired service members and their families. Family members include spouses and unmarried children, adopted children or stepchildren up to the age of 21 (or 23 if full-time students at approved institutions of higher learning and the sponsor provides at least 50 percent of the financial support). Other beneficiary categories are listed in the *TRICARE Eligibility* section.

**Beneficiary Counseling and Assistance Coordinators (BCACs)**
Persons at MTFs and TRICARE Regional Offices who are available to answer questions, help solve health care-related problems and assist beneficiaries in obtaining medical care through TRICARE. BCACs were previously known as Health Benefits Advisors (HBAs). To locate a BCAC, visit **www.TRICARE.mil/BCACDCAO.**

**Catastrophic Cap**
The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given Fiscal Year (October 1 to September 30). Point-Of-Service (POS) cost-shares and the POS deductible are not applied to the catastrophic cap.

**Catchment Area**
Geographic areas determined by the Assistant Secretary of Defense (Health Affairs) that are defined by a set of five-digit ZIP codes, usually within an approximate 40-mile radius of a military inpatient treatment facility.

**Note:** Humana Military — and all other contractors responsible for administering TRICARE — is required to offer TRICARE Prime in each catchment area.

**CHAMPUS Maximum Allowable Charge (CMAC)**
A nationally determined allowable charge level that is adjusted by locality indices and is equal to or greater than the Medicare Fee Scheduled amount. CMAC is the TRICARE allowable charge for covered services when appropriately applied to services priced under CMAC.

**Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)**
The federal health benefits program for eligible family members of 100 percent totally and permanently disabled veterans. CHAMPVA is administered by the Department of Veterans Affairs and is a separate federal program from the Department of Defense TRICARE program.

For question regarding CHAMPVA, call **1-800-733-8387** or email **hac.inq@va.gov.**

**Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)**
The health care program established to provide purchased health care coverage for ADFMs and retired service members and their family members outside the military's direct care system. TMA was organized as a separate office under the Assistant Secretary of Defense and replaced CHAMPUS in 1994. The purchased care benefits authorized under the CHAMPUS law and regulations are now covered under TRICARE Standard.

**Corporate Services Provider (CSP)**
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.

**Credentialing**
The process by which providers are allowed to participate in the TRICARE network. This includes a review of the provider's training, educational degrees, licensure, practice history, etc.

**Defense Enrollment Eligibility Reporting System (DEERS)**
A database 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.

**Designated Provider (DP)**
Under the US Family Health Plan (USFHP), DPs (formerly known as uniformed services treatment facilities) are selected civilian medical facilities around the United States assigned to provide care to eligible and enrolled 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.

**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.

**Extended Care Health Option (ECHO)**
A supplemental program to the TRICARE basic program. It provides eligible and enrolled ADFMs with additional benefits for an integrated set of services and supplies designed to assist in the treatment and/or 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.

**Foreign Identification Number (FIN)**
A permanent identification number assigned to a North Atlantic Treaty Organization (NATO) beneficiary by the appropriate national embassy. The number resembles a Social Security Number and most often starts with 6 or 9. TRICARE will not issue an authorization for treatment or services to NATO beneficiaries without a valid FIN.

**Managed Care Support Contractor (MCSC)**
A civilian health care contractor of the Military Health System (MHS) that administers TRICARE in one of the TRICARE regions. Humana Military is an MCSC. An MCSC helps combine the service available at MTFs with those offered by the TRICARE network of civilian hospitals and providers to meet the health care needs of the TRICARE beneficiaries.

**Military Treatment Facility (MTF)**
A medical facility (e.g., hospital, clinic, etc.) owned and operated by one of the component services of the Department of Defense (e.g., U.S. Army, U.S. Navy, U.S. Air Force) and usually located on or near a military installation.

**National Provider Identifier (NPI)**
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. The National Plan and Provider Enumeration System (NPPES) assigns NPIs to providers.

**Nonavailability Statement (NAS)**
A certification by a commander (or a designee) of a uniformed services medical treatment facility, recorded in DEERS, generally for the reason that the needed medical care being requested by a non-TRICARE Prime enrolled beneficiary cannot be provided at the facility concerned because the necessary resources are not available in the timeframe needed.

**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 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. TRICARE OPPS became effective May 1, 2009.

**Point Of Service (POS)**
The option under TRICARE Prime that allows enrollees to self-refer for nonemergency health care services to any TRICARE-authorized civilian provider, in or out of the network. When Prime enrollees choose to use the POS option (i.e., to obtain nonemergency health care services from other than their PCMs or without a referral from their PCMs), all requirements applicable to TRICARE Standard apply except the requirement for a NAS. POS claims are subject to deductibles and cost-shares even after the enrollment/Fiscal Year catastrophic cap has been met. The POS option is not available to ADSMs.

**Primary Care Manager (PCM)**
An MTF provider, team of providers or a network provider to whom a beneficiary is assigned for primary care services at the time of enrollment in TRICARE Prime. Enrolled beneficiaries agree to initially seek all nonemergency, non-behavioral health care services from their PCMs.

**Prime Service Area (PSA)**
The geographic area where TRICARE Prime benefits are offered. This includes all catchment areas, BRAC sites, a 40-mile radius around all MTFs and all additional areas proposed by the regional MCSC.

**Split Enrollment**
Split enrollment refers to multiple family members enrolled in TRICARE Prime under different TRICARE regions or MCSCs.

**Sponsor**
The ADSM, retiree or deceased service member or former service member through whom family members are eligible for TRICARE.

**Supplemental Health Care Program (SHCP)**
A program for eligible uniformed services members and other designated patients who require medical care that is not available at the MTF upon the approval of the cognizant MTF commander or the TMA director, as required, to be purchased from civilian providers under TRICARE payment rules.

**Transitional Assistance Management Program (TAMP)**
A program that provides 180 days of transitional health care benefits to help certain uniformed services members and their families transition to civilian life.

**Transitional Care**
Designed for all beneficiaries to ensure a coordinated approach takes place across the continuum of care.

# Notes

# List of Figures

# Notes

# Index

## A



## B

## C

## D



## E

## F



## G



## H



## I



## K



## L

## M



## N

## O



## P

## Q



## R



## S

## T



## U

## V



## W



## X



## Z

# Notes

# Notes

# Notes

# Notes

# Notes

TRICARE®

South Region

# 2013 Provider Handbook

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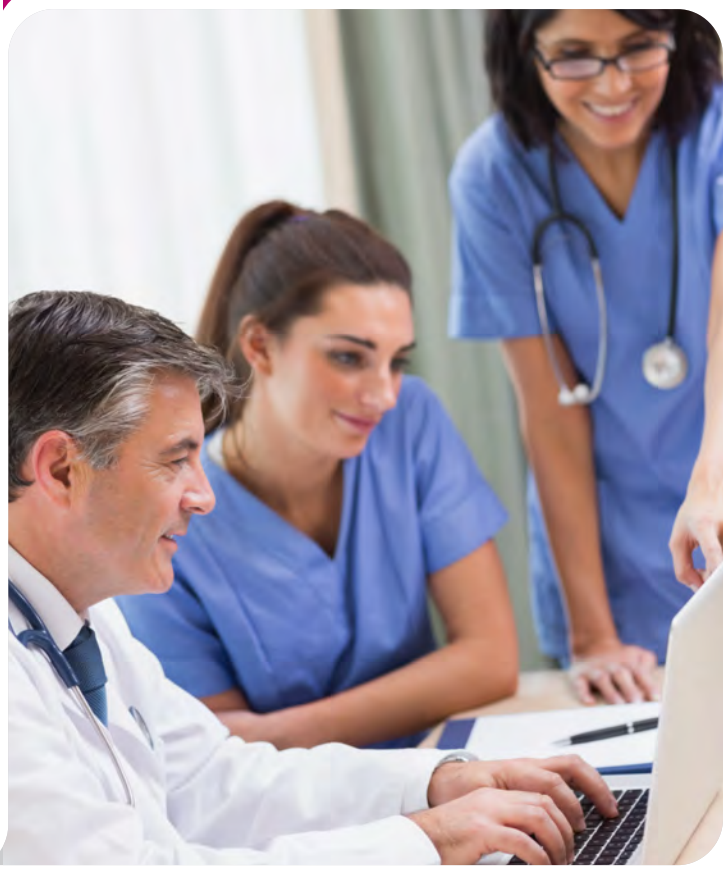

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