An Important Note about TRICARE Program Information

This TRICARE Provider Handbook will assist you in delivering TRICARE benefits and services. At the time of printing, the information in this handbook is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulation. Changes to TRICARE programs are continually made as public law and/or federal regulation are amended. For the most recent information, contact Health Net Federal Services, LLC, at 1-877-TRICARE (1-877-874-2273) or visit www.healthnetfederalservices.com. More information regarding TRICARE can also be found online at www.tricare.mil. Contracted TRICARE providers are obligated to abide by the rules, procedures, policies, and program requirements as specified in this TRICARE Provider Handbook, which is a summary of the TRICARE regulations and manual requirements related to the program. TRICARE regulations are available on the TRICARE Management Activity Web site at www.tricare.mil.
This TRICARE Provider Handbook has been developed to provide 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. Colored text throughout the handbook indicates content that has been added or updated since the last edition. Deletions are not indicated.

TRICARE program changes and updates may be communicated periodically through the TRICARE Provider News publications. The TRICARE Provider Handbook is updated annually. You may access the most recent version of this handbook and copies of the TRICARE Provider News publications through the Health Net Federal Services, LLC Web site at www.healthnetfederalservices.com, or you can request additional handbooks by calling 1-877-TRICARE (1-877-874-2273).

Give Us Your Opinion

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

Please provide feedback on this handbook by participating in the survey available at www.tricare.mil/evaluations/handbooks.

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

Using This TRICARE Provider Handbook

This TRICARE Provider Handbook has been developed to provide 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. Colored text throughout the handbook indicates content that has been added or updated since the last edition. Deletions are not indicated.

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

What Is TRICARE?

TRICARE is the uniformed services* health care program for active duty service members and their families, retired service members and their families, members of the National Guard and Reserve and their families, survivors, and others who are eligible. TRICARE’s primary objectives are to optimize the delivery of health care services in the military’s direct care system for all Military Health System (MHS) beneficiaries and attain the highest level of patient satisfaction through the delivery of a world-class health care benefit.

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

TRICARE is managed regionally in three separate TRICARE regions in the United States—TRICARE North, TRICARE South, and TRICARE West—and one overseas region divided into three areas—TRICARE Europe, TRICARE Pacific, and TRICARE Latin America and Canada. In the United States, TRICARE is managed jointly by the TRICARE Management Activity (TMA) and TRICARE Regional Offices. TMA has partnered with civilian managed care support contractors (MCSCs) 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.


TRICARE Regions

North Region
Health Net Federal Services, LLC
Customer Service Line:
1-877-TRICARE (1-877-874-2273)
www.healthnetfederalservices.com

South Region
Humana Military Healthcare Services, Inc.
Customer Service Line: 1-800-444-5445
www.humana-military.com

West Region
TriWest Healthcare Alliance Corp.
Customer Service Line:
1-888-TRIWEST (1-888-874-9378)
www.triwest.com/provider
Your Managed Care Support Contractor

Health Net Federal Services, LLC (Health Net) is responsible for administering the TRICARE program for more than 2.9 million TRICARE beneficiaries in the TRICARE North Region. The North Region includes Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin, and portions of Tennessee (Fort Campbell area only), Iowa (Rock Island Arsenal area only), and Missouri (St. Louis area only).

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

Health Net TRICARE Contract Administration

The administration of the TRICARE contract is developed and maintained by Health Net. Health Net utilizes various partnerships for some services:

• The medical or surgical network is developed and maintained by Health Net.
• The behavioral health network is developed and maintained by MHN, Inc. (MHN).
• Claims processing and claims customer service activities are provided and maintained by PGBA, LLC (PGBA).

Provider Resources

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

Health Net Web Site: www.healthnetfederalservices.com

The Health Net Web site at www.healthnetfederalservices.com, along with the PGBA-maintained www.myTRICARE.com Web site, offers program specifics, business tools, and other information about TRICARE operations in the North Region. TRICARE benefits, patient responsibility, referral and authorization requirements, preventive care, frequently asked questions, and timely news and program updates can all be accessed through the site. Web site registration is required to access the following tools and services:

• Patient eligibility: Verify TRICARE eligibility, other health insurance status, and deductible and catastrophic cap expenses.

• Referral and prior authorization: Use the Referral Decision Tool and Prior Authorization Determination Tool to determine referral and prior authorization requirements. Referral and prior authorization requests can be made online, and you can also check the status of your request.

• Claims: Check claims status, submit claims online using XPressClaim™, create DataMart℠ reports to view patient claims history, set up electronic funds transfer, and view remits online.

• Customer service: Access TRICARE provider materials and forms, as well as send secure e-mail and have questions answered using Web Chat.

Through the site, you may also access key features on other related TRICARE Web sites, including TRICARE-allowable charge rates, “Healthy People 2010” information, and useful links that assist in managing medical care.


Health Net operates a toll-free customer service line, 1-877-TRICARE (1-877-874-2273), offering extended hours from 7 a.m. to 7 p.m. Eastern Time and from 6 a.m. to 6 p.m. Central Time. The customer service line is staffed with trained representatives versed in policies, procedures, claims, referrals, authorizations, and other TRICARE requirements. You may
also choose to use the Interactive Voice Response (IVR) feature, which allows 24-hour, seven-days-a-week access to self-service options, including claims status, eligibility inquiries, and TRICARE-allowable charge rates.

**TRICARE Manuals Online:**  
http://manuals.tricare.osd.mil

This TRICARE Provider Handbook is a summary of the regulations and requirements related to the TRICARE program. The TRICARE Policy Manual, TRICARE Operations Manual, and TRICARE Reimbursement Manual may be viewed in their entirety online at http://manuals.tricare.osd.mil.

### TRICARE Service Centers

TRICARE Service Centers (TSCs) are located throughout the North Region and are staffed with customer service representatives to assist both beneficiaries and providers. Please refer beneficiaries to these locations or to the Health Net toll-free customer service line at 1-877-TRICARE (1-877-874-2273) if they need assistance with TRICARE. MTF providers may interact with TSC staff for many health care services or administrative actions.

### Other Provider Resources

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

### Provider Resources

**Figure 1.1**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>AudioHealth® Library</td>
<td>A 24-hour health and medical topic information line for TRICARE beneficiaries</td>
<td>1-877-TRICARE (1-877-874-2273)</td>
</tr>
</tbody>
</table>
| Benefits and Patient Responsibility          | Inquire about TRICARE-covered and non-covered benefits and patient financial responsibility | www.healthnetfederalservices.com  
1-877-TRICARE (1-877-874-2273)  
1-800-555-2605 for TRICARE Reserve Select |
| Claims                                        | For all claims-related questions                                             | www.healthnetfederalservices.com  
www.myTRICARE.com  
1-877-TRICARE (1-877-874-2273)               |
1-800-621-8335  
American Medical Association  
515 N. State Street  
Chicago, IL 60654 |
| Electronic Claims                             | For questions concerning the electronic data interchange (EDI)             | www.myTRICARE.com  
1-877-EDI-CLAIM (1-877-334-2524)          |
| Eligibility                                   | Verify TRICARE patient eligibility                                          | www.healthnetfederalservices.com  
www.myTRICARE.com  
1-877-TRICARE (1-877-874-2273)               |
| Fraud and Abuse Hotline                       | To report suspected fraud or abuse                                          | www.healthnetfederalservices.com  
1-800-977-6761                           |
<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 Diagnosis Coding Manual and HCPCS Procedure Coding Manual</td>
<td>To obtain copies or if you need assistance</td>
<td><a href="http://www.ingenixonline.com">www.ingenixonline.com</a>&lt;br&gt;1-800-INGENIX (1-800-464-3649), option 1&lt;br&gt;Ingenix&lt;br&gt;2525 Lake Park Boulevard&lt;br&gt;Salt Lake City, UT 84120</td>
</tr>
<tr>
<td>Military Medical Support Office (MMSO)</td>
<td>For written or phone inquiries to Army, Navy, Air Force, Marine Corps, Coast Guard, and National Guard regarding appeals when representing the active duty service member</td>
<td>1-888-647-6676&lt;br&gt;Military Medical Support Office&lt;br&gt;P.O. Box 886999&lt;br&gt;Great Lakes, IL 60088-6999</td>
</tr>
<tr>
<td>National Oceanic and Atmospheric Administration (NOAA) and U.S. Public Health Service (USPHS)</td>
<td>For medical or dental inquiries regarding NOAA and USPHS personnel</td>
<td>1-877-TRICARE (1-877-874-2273)</td>
</tr>
<tr>
<td>Prior Authorization and Referral Requests</td>
<td>Prior authorizations for inpatient and select outpatient procedures requiring approval prior to receiving care or referral requests from Health Net. Submit requests online or fax the TRICARE Service Request/Notification Form.</td>
<td><a href="http://www.healthnetfederalservices.com">www.healthnetfederalservices.com</a>&lt;br&gt;1-877-TRICARE (1-877-874-2273)&lt;br&gt;Fax: 1-888-299-4181</td>
</tr>
<tr>
<td>Prior Authorization and Referral Requirements</td>
<td>Determine if a referral from Health Net is required</td>
<td>Referral Decision Tool and Prior Authorization Determination Tool available on the Health Net Provider Portal at <a href="http://www.healthnetfederalservices.com">www.healthnetfederalservices.com</a></td>
</tr>
<tr>
<td>Prior Authorization and Referral Status Check</td>
<td>For immediate status updates on prior authorization and referral requests</td>
<td><a href="http://www.healthnetfederalservices.com">www.healthnetfederalservices.com</a>&lt;br&gt;www.myTRICARE.com&lt;br&gt;1-877-TRICARE (1-877-874-2273)</td>
</tr>
<tr>
<td>Provider Locator Services</td>
<td>Representatives who help locate TRICARE providers and applicable community/state/federal health care resources for beneficiaries who require benefits and services beyond TRICARE</td>
<td>1-877-TRICARE (1-877-874-2273)</td>
</tr>
<tr>
<td>Provider Status Verification and Updates</td>
<td>For network and non-network civilian provider contracting and certification status inquiries, as well as demographic and tax identification number updates</td>
<td>1-877-TRICARE (1-877-874-2273)</td>
</tr>
</tbody>
</table>
**Healthy People 2010—Be a Part of the Success**

Healthy People 2010 is a broad-based collaborative effort among scientific experts in government, private, public, and nonprofit organizations. This collaboration, which is managed by the Office of Disease Prevention and Health Promotion and the U.S. Department of Health and Human Services, has set national disease-prevention and health-promotion objectives to be achieved by the year 2010. Healthy People 2010 is designed to serve as a road map for improving the health of all people in the United States. It is a valuable resource in determining how you can participate most effectively in improving the nation’s health.

### Goals of Healthy People 2010

Healthy People 2010 has two main goals that apply to all of its objectives:

- To increase the quality and length of healthy life
- To eliminate health disparities among all populations

### Components of Healthy People 2010

Healthy People 2010 features 467 science-based objectives and 10 leading health indicators. These indicators are high-priority public health issues that use a smaller set of objectives to track progress toward meeting the Healthy People 2010 goals. The leading health indicators represent the important determinants of health for the full range of issues in the 28 focus areas of Healthy People 2010.

### The Leading Health Indicators

Each leading health indicator is an important health issue in and of itself. The indicators are intended to help everyone more easily understand how healthy we are as a nation. They are the most important areas in which individuals can make changes to improve their own health and the health of their families and communities. Each indicator depends to some extent on:

- The information people have about their health and how to make improvements
- Behavioral factors—the choices people make
- Environmental, economic, and social conditions
- Access to health care and the type, amount, and quality of health care people receive

The 10 leading health indicators are:

- Access to health care
- Behavioral health
- Environmental quality
- Immunization
- Injury and violence
- Overweight and obesity
- Physical activity
- Responsible sexual behavior
- Substance abuse
- Tobacco use

### Provider Resources (continued)

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRICARE-Allowable Charge Rates</td>
<td>View and download TRICARE-allowable charge rates</td>
<td><a href="http://www.tricare.mil/cmac">www.tricare.mil/cmac</a></td>
</tr>
<tr>
<td>TRICARE For Life and Dual-Eligible Beneficiary Claims</td>
<td>For questions or assistance concerning TRICARE For Life (TFL) and dual-eligible beneficiary (Medicare and TRICARE) claims</td>
<td><a href="http://www.TRICARE4u.com">www.TRICARE4u.com</a> 1-866-773-0404 1-866-773-0405 (TDD)</td>
</tr>
<tr>
<td>TRICARE Manuals Online</td>
<td>Access links to TRICARE regulatory guidance, policy, and procedures</td>
<td><a href="http://manuals.tricare.osd.mil">http://manuals.tricare.osd.mil</a></td>
</tr>
</tbody>
</table>
What Can You Do?

- Understand the role that prevention, health promotion, and community-based health programs have on the determinants of health.
- Integrate Healthy People 2010 initiatives into current programs, special events, publications, and meetings.
- Utilize national health observances (e.g., Great American Smokeout or American Heart Month) that align with leading health indicators and focus areas that have been identified in your community.
- Monitor community-based and community-determined well-being initiatives to improve “community capacity” and improve overall wellness.
- Understand the health care provider role and how you and your patients can benefit.
- Encourage patients to pursue healthier lifestyles and to participate in community-based programs.
- Be aware of the Healthy People 2010 resources and refer to them to assist you in developing and implementing programs and interventions for your patients.

Healthy People 2010 Resources

- Healthy People 2010:
  - Web site: www.healthypeople.gov
  - Phone: 1-800-367-4725
- For printed manuals and other resources, write to:
  Office of Disease Prevention and Health Promotion Communication Support Center
  P.O. Box 37366
  Washington, DC 20013-7366

- Office of Disease Prevention and Health Promotion Web site:
  
  www.odphp.osophs.dhhs.gov

- Web site for thousands of free federal health promotion and disease prevention documents:
  
  www.healthfinder.gov

References:

- Healthy People 2010 Web site: www.healthypeople.gov
Important Provider Information

TRICARE Policy Resources

Provisions of the U.S. Constitution authorize Congress to make laws by passing an act (e.g., National Defense Authorization Act for Fiscal Year 2009). When an act is passed by Congress and signed by the president, it becomes a federal law, which generally supersedes any state law (unless it specifies that a state law may apply). An act can be codified in a number of statutes. These statutes are classified and coded in the United States Code. Title 10 of the United States Code houses all statutes regarding the armed forces.

When an act relevant to TRICARE becomes law, the Department of Defense (DoD), through the TRICARE Management Activity (TMA), directs Health Net Federal Services, LLC (Health Net) on how to administer that law. This direction comes through modifications to the Code of Federal Regulations (CFR). The TRICARE Operations Manual, TRICARE Reimbursement Manual, and TRICARE Policy Manual are updated continually to reflect changes in the CFR. Depending on the complexity of the law and federal funding, it can take a year or more before direction from DoD is given through TMA and Health Net can begin administration of the new policy.

For the most current information about TRICARE policy changes, refer to the TRICARE manuals at http://manuals.tricare.osd.mil as well as the TRICARE Provider News publications that include articles featuring policy changes and how and when they should be implemented.

DoD to Remove Social Security Numbers from ID Cards

In response to an increasing awareness of the growing need to protect the identity information of service members and their families, the DoD will begin to remove Social Security Numbers (SSNs) from DoD identification (ID) cards.

Despite the fact that SSNs will be removed from DoD ID Cards, TRICARE will continue to base all operations (e.g., eligibility verification, claims submission, appeals) on the sponsor’s SSN.

While TRICARE beneficiaries are being educated about this transition, extra care should be taken to solicit an accurate sponsor’s SSN from the beneficiary at the time of service to support your business operations. You may continue to copy DoD ID cards for your records; however, the SSN is being removed.

SSN removal will occur in three phases:

- Phase one, affecting family member ID cards, began in 2008
- Phase two will remove all printed SSNs and will begin in 2009
- Phase three will remove SSN information embedded in barcodes and will begin during 2012

These changes are being made upon ID card renewal.

Note: The sponsor’s ID card will retain the last four digits of the SSN; however, it will not be identified on family member ID cards.

For more detailed information regarding the SSN Reduction Plan, please visit www.dmdc.osd.mil/smartcard.

Health Insurance Portability and Accountability Act of 1996

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

All health plans, health care clearinghouses, and health care providers who conduct certain financial and administrative transactions electronically must comply with HIPAA.

The TRICARE health plan, military treatment facilities (MTFs), providers, TRICARE contractors, subcontractors, clearinghouses, and other business associates fall within these categories.
In compliance with the portability portion of HIPAA, the Military Health System (MHS), through the Defense Manpower Data Center Support Office, issues certificates of creditable coverage automatically to beneficiaries who lose TRICARE coverage. For additional information, visit the TRICARE Web site at www.tricare.mil/tma/hipaa/cocc.aspx.

Under the Administrative Simplification portion of HIPAA, the Department of Health and Human Services has published five rules for HIPAA compliance:

- **Transactions and Code Sets Rule**
  Published: August 17, 2000
  Compliance date: October 16, 2003

- **Privacy Rule**
  Published: December 28, 2000
  Compliance date: April 14, 2003

- **Employer Identifier Rule**
  Published: May 31, 2002
  Compliance date: July 30, 2004

- **Security Rule**
  Published: February 20, 2003
  Compliance date: April 21, 2005

- **National Provider Identifier (NPI) Rule**
  Published: January 23, 2004
  Compliance date: May 23, 2007

Effective April 14, 2003, the HIPAA Privacy Rule provisions were implemented nationwide and all covered entities, including providers, were required to be in full compliance with the Privacy Rule.

Effective October 16, 2003, HIPAA standard electronic transactions were implemented within the MHS.

Effective July 30, 2004, the Employer Identifier Rule provisions were implemented nationwide and all covered entities, including providers, were required to be in full compliance with the Employer Identifier Rule.

Effective April 21, 2005, the HIPAA Security Rule provisions were implemented nationwide and all covered entities, including providers, were required to be in full compliance with the Security Rule.

On April 2, 2007, the Centers for Medicare and Medicaid Services (CMS) published guidance to the health care industry regarding NPI contingency planning. For a 12-month period after the compliance date (i.e., through May 23, 2008), CMS decided not to impose penalties on covered entities that deployed contingency plans to ensure the smooth flow of payments provided those entities made reasonable and diligent efforts to become compliant and, in the case of health plans (that are not small health plans), to facilitate the compliance of their trading partners. Specifically, as long as a health plan (that is not a small health plan) could demonstrate to CMS its active outreach and testing efforts, it could continue processing payments to providers. In determining whether a good-faith effort had been made, CMS placed a strong emphasis on sustained actions and demonstrable progress.

CMS encouraged covered entities to assess the readiness of their communities and determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance.

**Guidelines for Implementing the HIPAA Privacy Rule**

As required by the HIPAA Privacy Rule, provider offices/groups must train all members of their workforces on the policies and procedures with respect to protected health information (PHI) as necessary to carry out their function. Appropriate safeguards must be in place that provide security to PHI from an administrative, technical, and physical standpoint. Providers must reasonably safeguard PHI from any intentional or unintentional use or disclosure that is in violation of the standards, implementation specifications, or other requirements of the standard.

Providers are permitted by the HIPAA Privacy Rule to make use and disclosure of an individual’s PHI for purposes of treatment, payment, and health care operations. PHI is the information created and obtained as providers deliver services to beneficiaries. Such information may include documentation of symptoms, examination and test results, diagnoses, treatments, and applying
for future care or treatment. It also includes billing documents for those services.

In addition, providers are permitted to use PHI for health care operations without being required to obtain a release or authorization for activities such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance.

Disclosures that do not have to be included for the HIPAA Privacy Rule include:

- Releases for treatment, payment, or health care operations
- Releases to the individual
- Releases occurring with a patient’s written authorization
- Releases for the directory or other persons involved in the individual’s care
- Releases to national security or intelligence agencies
- Releases to correctional institutions or law enforcement as provided in 45 CFR Section 164.512(k)(5)

HIPAA requires that all PHI be kept completely confidential. PHI is defined as information about individuals or beneficiaries that contains the following data:

- Home address
- Home telephone number
- Race
- SSN
- Medical records
- Photographs
- Any information that may compromise the privacy of or prove harmful to the beneficiary (See 45 CFR Section 160.103 for PHI definition.)

Some state laws contain more stringent requirements than those required by the federal regulation under HIPAA. Providers must be familiar with both federal and state regulations and comply with their requirements in their entirety.

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

**MHS Notice of Privacy Practices**

The MHS Notice of Privacy Practices informs beneficiaries how PHI may be used or disclosed, with whom that information may be shared, the safeguards in place to protect it, and patients’ rights regarding PHI. The notice has been published in nine languages, including Braille, and an audio version is available for vision-impaired beneficiaries.

Privacy officers are located at every MTF. They serve as beneficiary advocates for privacy issues and will respond to inquiries from TRICARE beneficiaries regarding their PHI. Beneficiaries may contact their privacy officer if they have questions about the MHS Notice of Privacy Practices or about their privacy rights. Beneficiaries may also visit the TRICARE Web site at www.tricare.mil/hipaa for more information about privacy practices or other HIPAA requirements. Specific questions about HIPAA may be sent via e-mail to Privacymail@tma.osd.mil.

If you or your staff would like copies of the MHS Notice of Privacy Practices, visit the TRICARE Web site at www.tricare.mil/tmaprivacy.

**HIPAA Transactions and Code Sets**

The HIPAA Transactions and Code Sets Rule mandates the use of electronic standards for certain administrative and financial health care transactions. Compliance with this rule was mandated for October 16, 2003.

Figure 2.1 on the following page lists the mandated HIPAA electronic transactions.

The MHS and the TRICARE program are now HIPAA-compliant with standard transactions and code sets. Where these business functions are performed electronically, the HIPAA standards are now in use. For more information, visit the TRICARE HIPAA Web site at www.tricare.mil/hipaa/transactions.aspx.
HIPAA NPI

The HIPAA NPI Final Rule, published in the Federal Register January 23, 2004, required adoption of the NPI as the standard unique identifier for health care providers. The compliance date for using NPIs in HIPAA standard electronic transactions was May 23, 2007. However, TRICARE invoked a 12-month contingency period similar to the CMS contingency planning guidance, which allowed TRICARE to process transactions with a legacy provider identifier, the NPI, or both until May 23, 2008. During this time TRICARE continued with ongoing collection and maintenance of provider NPIs, as well as testing of systems.

NPI enumeration of health care providers (i.e., assignment of NPIs to providers) and maintenance of NPI-associated data are being conducted through the National Plan and Provider Enumeration System (NPPES). The NPPES is the central system for identifying and uniquely enumerating health care providers at the national level. By now, TRICARE providers should have already obtained their NPIs.

Any provider who has not obtained an NPI can do so through the NPPES Web-based application at https://nppes.cms.hhs.gov or by submitting a paper application that can be found at www.cms.hhs.gov/cmsforms/downloads/cms10114.pdf. A copy of the application can also be obtained by request from the NPI Enumerator in one of the following ways:

- **Phone**
  - 1-800-465-3203 (toll-free)
  - 1-800-692-2326 (toll-free TTY)

- **E-mail**
  - customerservice@npienumerator.com

- **Mail**
  - NPI Enumerator
  - P.O. Box 6059
  - Fargo, ND 58108-6059

For more NPI information, visit the CMS Web site at www.cms.hhs.gov/NationalProvIdentStand. For TRICARE-specific NPI information, visit www.tricare.mil/tma/hipaa/identifiers.aspx.
Registered myTRICARE.com providers can submit their NPI(s) to Health Net through the Web. After logging onto www.myTRICARE.com, click on the “NPI” tab at the top of the screen. If you do not have Internet access, you may fax your NPI information to 1-888-244-4025. If you have questions about how to submit your NPI to Health Net, please call our toll-free EDI Help Desk at 1-877-EDI-CLAIM (1-877-334-2524).

**HIPAA Employer Identifier**

The National Employer Identifier Final Rule was published on May 31, 2002. Covered entities were required to be compliant with this rule as of July 30, 2004. For HIPAA purposes, employers are defined as the sponsors of health insurance for their employees. The standard selected for the national employer identifier is the employer identification number (EIN) as issued by the Internal Revenue Service (IRS). This number is the EIN that appears on an employee’s IRS Form W-2 Wage and Tax Statement and is the number that will be used to identify that employer in standard electronic health care transactions. Covered health care providers, health plans, and health care clearinghouses must accept and transmit the EIN where required in electronic health care transactions.

**TRICARE Provider Types**

TRICARE defines a provider as a person, business, or institution that provides or gives health care. For example, a doctor is a provider. A hospital is a provider. An ambulance company is a provider. There are many other provider types. A provider must be authorized under the TRICARE regulation and must have their authorized status verified (certified) by Health Net.

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

Figure 2.2 on the following page provides an overview of various TRICARE provider types.

**Corporate Services Provider Class**

The Corporate Services Provider Class consists of institutional-based or freestanding corporations and foundations that render professional, ambulatory, or in-home care, and technical diagnostic procedures. Some of the specific types of providers who fall within this category may include:

- Cardiac catheterization clinics
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Diabetic outpatient self-management education programs (American Diabetes Association® accreditation)
- Freestanding bone marrow transplant centers
- Freestanding kidney dialysis centers
- Freestanding magnetic resonance imaging (MRI) centers
- Freestanding sleep disorder diagnostic centers
- Home health agencies (HHAs) (pediatric or maternity management)
- Home infusion (Accreditation Commission for Health Care [ACHC] accreditation)
- Independent physiological laboratories
- Radiation therapy programs

**Certification**

Network corporate services providers are certified during the credentialing process. Contact Health Net at 1-877-TRICARE (1-877-874-2273) for more information.

Non-network corporate services providers must apply to become a TRICARE-authorized provider. Qualified non-network providers can find the Application for TRICARE Provider Status/Corporate Services Provider application at www.myTRICARE.com. For corporate services provider conditions for coverage and reimbursement of services, refer to the TRICARE Policy Manual, Chapter 11, Section 12.1 on the TRICARE Website at http://manuals.tricare.osd.mil.

**Billing**

Home health providers designated as corporate services providers are exempt from prospective payment system billing rules associated with home health care.
**Note:** The actual provider who renders the care must still be identified on the claim form.

**Military Treatment Facilities**

An MTF is a medical facility (hospital, clinic, etc.) owned and operated by the uniformed services—usually located on or near a base. The civilian provider network augments the resources available in the MTF. For a complete list of MTFs in the North Region, use the MTF Locator at [www.tricare.mil/mtf](http://www.tricare.mil/mtf) or visit the Health Net Web site at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com). Network providers may work closely with MTF providers near them.

**MTF Right of First Refusal**

MTFs are given the “right of first refusal” for TRICARE Prime beneficiaries residing in a TRICARE Prime Service Area (PSA) of an MTF for referrals for inpatient admissions, specialty appointments, and procedures requiring written prior authorization, providing the MTF has the capability to render the service requested by a civilian provider. This means TRICARE Prime beneficiaries must first try to obtain these services at the MTF. The MTF staff will review the referral to determine if they have the specialty capability and an available specialty care appointment within the access standards. If the service is not available at the MTF within the appropriate access standards, then the beneficiary is referred to a TRICARE network provider.

**Veterans Affairs Facilities**

Health Net will give network provider information to the Department of Veterans Affairs (VA). TRICARE network providers are asked to accept requests from VA to provide care to veterans. VA may contact network providers and request health care services for veteran patients on a case-by-case basis. Network providers need to notify Health Net on a monthly basis of such requests for services. The provider is not obligated to see the veteran patient, but is encouraged to do so. If the provider chooses to see the patient, health care services, medical documentation, and reimbursement will be coordinated between the referring VA Medical Center (VAMC) and the provider directly. The patient will provide referral information and instructions for seeking reimbursement from the VAMC to the provider at the time of the visit.

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**TRICARE Provider Types**

<table>
<thead>
<tr>
<th>TRICARE-Authorized Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• TRICARE-authorized providers are those who meet TRICARE’s licensing and certification requirements and have been certified by TRICARE to provide care to TRICARE beneficiaries. These include doctors, hospitals, ancillary providers (such as laboratory and radiology providers), and pharmacies.</td>
</tr>
<tr>
<td>• There are two types of TRICARE-authorized providers: <strong>Network</strong> and <strong>Non-network</strong>.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Network Providers¹</th>
<th>Non-Network Providers²</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Have a signed agreement with Health Net to provide care.</td>
<td>• Do not have a contractual relationship with Health Net.</td>
</tr>
<tr>
<td>• Agree to file claims and handle other paperwork for TRICARE beneficiaries.</td>
<td>• There are two types of non-network providers: <strong>Participating</strong> and <strong>Nonparticipating</strong>.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Have agreed to file claims for TRICARE beneficiaries, to accept payment directly from TRICARE, and to accept the TRICARE-allowable charge as payment in full for their services.</td>
<td>• Have not agreed to accept the TRICARE-allowable charge or file claims for TRICARE beneficiaries.</td>
</tr>
<tr>
<td>• May choose to participate on a claim-by-claim basis.</td>
<td>• Have the legal right to charge beneficiaries up to 15% above the TRICARE-allowable charge for services.</td>
</tr>
</tbody>
</table>

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1. All network providers are required to have malpractice insurance.
2. For information on how to become a network provider, visit [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com) or call 1-877-TRICARE (1-877-874-2273).
service. VA and the provider may establish a direct contract relationship if they so desire.

Health Net will also give network provider information to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA is not a TRICARE program; however, network providers can choose to provide services to CHAMPVA beneficiaries on a space-available basis. Providers are encouraged to adhere to access standards when possible, while maintaining the priority of appointments with their TRICARE patients first. Network providers are requested to accept assignment for CHAMPVA beneficiaries and will notify Health Net on a monthly basis of such acceptances. The Health Net Web site at www.healthnetfederalservices.com has CHAMPVA claims processing instructions for submitting claims to VA for payment. Providers may also offer the negotiated TRICARE rate directly to CHAMPVA.

Provider Responsibilities

The following information outlines the roles and responsibilities for different classifications of TRICARE providers.

Office and Appointment Access Standards

TRICARE access standards are established so that beneficiaries can receive care within a reasonable distance from their home and in a timely manner. Network and MTF providers are obligated to adhere to the following access standards:

- Office wait times for nonemergencies should not exceed 30 minutes except when emergency care is being provided to patients, and the normal schedule is interrupted. This requirement provides some flexibility for the disruption of a provider’s normal schedule due to emergency situations. In those cases when providers are running behind schedule, they should notify patients of the cause for the delay and the length of delay anticipated, and offer to reschedule the appointment, if desired. Patients may choose to stay and keep their scheduled appointment.
- Wait times for appointments for wellness visits shall not exceed four weeks (28 days).
- Wait times for appointments for specialty visits shall not exceed four weeks (28 days).
- Wait times for appointments for routine visits shall not exceed one week.
- Wait times for the initial routine behavioral health care appointment with a behavioral health care provider may not exceed one week.
- Wait times for appointments for acute illness or urgent care shall not exceed 24 hours.
- Wait times for the initial urgent behavioral health care appointment with a behavioral health care provider shall generally not exceed 24 hours.

Health Net will contact network providers periodically to verify provider demographic information, panel status, and their ability to meet the appointment and access standards. Network providers must notify Health Net within 10 days of any change to this information.

Missed Appointments

TRICARE regulations do not prohibit providers from establishing practice policies regarding no-show fees. Providers who, as part of their practice standards, require beneficiaries to sign an agreement taking financial responsibility for missed appointments are within their rights to charge beneficiaries for missing an appointment. However, if no formal agreement is in place, the provider may not bill the beneficiary for the missed appointment.

TRICARE does not reimburse charges for missed appointments.

Primary Care Manager’s Role

TRICARE Prime beneficiaries agree to initially seek all nonemergency services from their primary care manager (PCM), a specified provider they selected for primary care services at the time of enrollment. The PCM is an individual provider within a military or a civilian location. Note: TRICARE Prime beneficiaries may not initially seek services from any provider except their PCM, unless they are:

- Utilizing the point of service (POS) option
- Seeking emergency care
Seeking clinical preventive services from a network provider

Seeking the first eight outpatient behavioral health care visits annually to a network provider

Note: ADSMs must **always** have a referral for all care outside of an MTF (*unless it is an emergency*), including all behavioral health care services. If the ADSM has an assigned civilian PCM under TRICARE Prime or TRICARE Prime Remote (TPR), all specialty referral and authorization guidelines must be followed.

The PCM’s roles and responsibilities are as follows:

- **Primary care services** are typically, although not exclusively, provided by internal medicine physicians, family practitioners, pediatricians, general practitioners, obstetricians, gynecologists, physician assistants, or nurse practitioners to the extent consistent with governing state rules and regulations.

- The PCM is responsible for performing primary care services and managing all of the care of his or her TRICARE Prime patients. The PCM must render care for acute illness, minor accidents, and follow-up care for ongoing medical problems as authorized in the TRICARE Prime benefits plan.

- When a provider signs a contractual agreement to become a PCM, the provider must follow TRICARE procedures and requirements for obtaining specialty referrals and prior authorizations for nonemergency inpatient and certain outpatient services. Claims submitted for services rendered without obtaining a required prior authorization are subject to a penalty based on the negotiated rate.

- 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. The PCM or on-call provider will determine the level of care needed:
  - **Routine care**—The PCM instructs the TRICARE Prime beneficiary to contact the PCM’s office on the next business day for an appointment.
  - **Urgent care**—The PCM or on-call provider coordinates timely care for the TRICARE Prime beneficiary.
  - The on-call physician 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 Health Net. Use the Referral Decision Tool at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com) to determine if a Health Net referral is required.

- When the PCM refers a TRICARE Prime beneficiary for specialty obstetric care, prior authorization must be obtained for both outpatient and inpatient services.

- The PCM enrollment panel should remain open to TRICARE beneficiaries. However, if the PCM determines that it is necessary to close his or her panel for a period of time, Health Net requests a 10-day advance notification.

**Specialty Care Referrals**

Specialty care referral requirements vary by TRICARE beneficiary type. In some cases, providers may also need to coordinate referrals with Health Net.

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

TRICARE Prime and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) beneficiaries must coordinate their referrals through PCM and network specialty care providers, except for emergency care, preventive care services from network providers, and the eight initial outpatient behavioral health visits to network providers, or when they choose to use the POS option.

**ADSMs, including TPR ADSMs**

ADSMs require a referral from Health Net for civilian (*network or non-network*) provider specialty care.

**TRICARE Standard Beneficiaries**

TRICARE Standard beneficiaries may self-refer to TRICARE-authorized providers.
**TRICARE For Life for Beneficiaries Eligible for TRICARE and Medicare**

TRICARE For Life (TFL) beneficiaries may self-refer to Medicare-certified, TRICARE-authorized providers.

**Health Net Referral Requirements by Beneficiary Category**

Certain types of TRICARE beneficiaries may require a referral from Health Net for specialty care. Providers can access the Referral Decision Tool located on the Health Net Web site at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com) to determine if a Health Net referral is required. To use the tool, select the beneficiary’s TRICARE program/plan option and PCM type (if a TRICARE Prime beneficiary), enter the beneficiary’s home ZIP code, and select “submit.” The tool will process the entry and identify whether Health Net requires a referral. If a Health Net referral is required, Health Net will also confirm if the MTF offers the specialty service being requested and determine its ability to accept the patient before care is referred to the civilian network.

**Specialty Care Provider’s Role**

The specialty care provider is responsible for rendering services to TRICARE beneficiaries when referred outside the PCM’s office for care. As previously defined under “Specialty Care Referrals,” some beneficiaries may require a referral from Health Net. When PCMs or specialty care providers contact Health Net for a referral, Health Net will first determine if specialty care services are available within the MTF. If not, Health Net will notify the PCM to refer the TRICARE Prime beneficiary to a civilian network provider or to a non-network provider if a network provider is not available. Network specialty care providers, in accordance with their network agreement, have the following responsibilities:

- **Important Clearly Legible Report (CLR) Information:** For care referred from an MTF to a civilian network provider, network providers must provide clearly legible consultation reports, operative reports, and discharge summaries to the initiating provider within seven business days of the beneficiary’s care. Behavioral health network providers also need to submit a brief initial assessment within seven business days. In urgent and emergency situations, a preliminary report of a specialty consultation should be conveyed to the beneficiary’s initiating provider within 24 hours (unless best medical practices dictate less time is required for a preliminary report) by telephone, fax, or other means. The written reports should be sent to the initiating provider in accordance with the instructions included with the referral or authorization for care from Health Net. For current information regarding the submission of CLRs, visit the Health Net Web site at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com).

  - Providers who agree to belong to the network sign agreements that obligate them to the rules and procedures required for referrals, prior authorizations, and their responsibilities as specialty providers. Claims submitted for services rendered without obtaining a required prior authorization are subject to a 10-percent penalty of the negotiated rate.

If a civilian specialty provider wants to refer a TRICARE patient to a sub-specialist, the specialty provider must contact the patient’s PCM only if the sub-specialty care is outside of the scope of the initial approved referral or prior authorization. The PCM will contact Health Net to request additional services when necessary according to the referral and prior authorization requirements. Refer to the Health Care Management and Administration section of this handbook for referral and prior authorization requirements.

Specialists can make requests to Health Net directly for additional visits or services when there is an “active” or already approved referral or prior authorization in place.

**Note:** If the PCM refers a patient for consultation only, Health Net will issue a referral for an initial consultation and one follow-up visit. Specialists cannot request additional visits or services for those types of “consult-only” authorizations. The beneficiary will need to coordinate with his or her PCM. Should additional services be required beyond the scope of the initial referral, the specialist will need to send another request.
for review to ensure continuity of care. A new referral (from either the PCM or Health Net) must be coordinated if additional care is required.

Release of Patient Information

If an inquiry is made by a beneficiary (including an eligible dependent child, regardless of age), the reply should be addressed to the beneficiary, not the beneficiary’s parent or guardian. The only exceptions are:

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

In responding to a parent of a minor or the guardian of an incompetent beneficiary, the Privacy Act of 1974 precludes disclosure of sensitive information, which, if released, could have an adverse effect on the beneficiary. Providers must not provide information to the parents or guardians of minors or incompetents when the services are related to the following diagnostic codes:

- **AIDS:**
  ICDM-9-CM 079.53; 042
- **Alcoholism:**
  ICDM-9-CM 291.9; 303–303.9; 305
- **Abortion:**
  ICDM-9-CM 634–639.9; 779.6
- **Drug Abuse:**
  ICDM-9-CM 292–292.2; 304–304.9; 305.2–305.9
- **Venereal Disease:**
  ICDM-9-CM 090–099.9; 294.1

TRICARE-eligible beneficiaries must maintain a “signature on file” in the physician’s office to protect the patient’s privacy, for the release of important information, and to prevent fraud.

Mentally incompetent or physically disabled TRICARE-eligible beneficiaries age 18 and older who are incapable of providing a signature may have a legal guardian appointed or a power of attorney (POA) 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.

For civilian providers, the first claims submission on behalf of the beneficiary should include the legal documentation establishing the guardian’s signature authority. Subsequent claims may be stamped with “Signature on File” in the beneficiary signature box of the CMS-1500 or UB-04 claim form.

- If the beneficiary is without legal representation, the physician of care must submit a written report with the claims describing the patient’s illness or degree of mental incompetence 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.
- When the beneficiary is mentally competent but physically incapable of a signature, the representative may be issued a general or limited power of attorney by signing an “X” in the presence of a notary representative.

Release of Medical Records

Health Net representatives must also comply with HIPAA privacy rules when TRICARE beneficiaries call regarding claims or other patient benefit information. There may be times when a TRICARE beneficiary requests information from Health Net on behalf of someone and Health Net cannot disclose that information until the proper legal paperwork has been submitted. If a beneficiary calls your office and indicates that Health Net would not speak with them, it may be for one of the following reasons:

- The person is calling on behalf of their spouse or adult child (age 18 or older; or age 21 or older in Pennsylvania and Indiana), but the adult patient has not submitted an **Authorization to Disclose Information Form** to Health Net.
- The person is the guardian (other than mother or father) of a child whose sponsor is a deployed ADSM but has not submitted a **POA document** to Health Net in order to discuss the child’s medical information.
- The person’s spouse is a deployed ADSM, and the ADSM has not submitted a **POA document** or other guardianship documents to Health Net in order to discuss that ADSM’s medical information.
• The person is divorced from the sponsor and there are children eligible under the sponsor, but a complete divorce decree establishing custodial rights has not been submitted to Health Net in order for the person to discuss the children’s medical information.

• The person is not married to his or her child’s sponsor and the child’s sponsor has not submitted an Authorization to Disclose Information Form to Health Net. If the child’s sponsor is not available, the custodial parent must submit a copy of the child’s birth certificate and proof of residence along with a letter explaining that they are the custodial parent and that judicial custody has not been established.

• The person’s last name is different than his or her spouse who is the child’s sponsor. The person with the same last name as the child needs to submit an Authorization to Disclose Information Form to Health Net.

• The person’s spouse or family member is deceased, but documentation of the appointment of legal representative for the estate has not been submitted to Health Net. If no legal representative has been established, a letter indicating that there is not a legal representative for the estate, as well as the person’s relationship to the deceased, can be submitted.

The Authorization to Disclose Information Form is located on the Health Net Web site at www.healthnetfederalservices.com. If you have additional questions about HIPAA privacy rules and TRICARE, call Health Net at 1-877-TRICARE (1-877-874-2273) or visit www.tricare.mil/tmaprivacy or www.hhs.gov/ocr/hipaa.

**Balance Billing and Other Health Insurance**

Providers are limited to collecting a specified amount, regardless of the beneficiary’s other health insurance (OHI) financial responsibility. Through a combination of reimbursements from OHI, TRICARE, and collection of the beneficiary’s TRICARE deductible, cost-share, or copayment, the provider must consider a claim paid in full. TRICARE beneficiaries are not responsible for any amounts above the balance-billing limits. Additionally, network providers cannot bill beneficiaries for non-covered services unless the beneficiary has agreed in advance and in writing to pay for these services. See “Hold Harmless Policy for Network Providers” later in this section.

Non-compliance with these balance-billing requirements by any TRICARE provider may affect that provider’s TRICARE and/or Medicare status. Additional information on this topic may be obtained by visiting www.tricare.mil.

“An Important Message from TRICARE”

Inpatient facilities are required to provide each TRICARE beneficiary with a copy of the document, “An Important Message from TRICARE.” This document details the beneficiary’s rights and obligations upon admission to the hospital. The signed document must be kept in the beneficiary’s file. A new document is needed for each admission. A sample of this document can be found on the Health Net Web site at www.healthnetfederalservices.com.

**Informing Beneficiaries about Non-Covered Services**

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

**Hold Harmless Policy for Network Providers**

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

• If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary, the provider may bill the beneficiary for services provided.

• If the beneficiary was informed that the services were excluded or excludable and he or she agreed in advance to pay for the services, the provider may bill the beneficiary.
TRICARE beneficiaries must be properly informed in advance and in writing of specific services or procedures that are not covered under TRICARE before they are provided. If they choose to be financially responsible for the non-covered services, beneficiaries may sign a waiver agreeing to pay for non-covered services.

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

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

However, if the network provider does not obtain a legal signed waiver, and the care is not authorized by Health Net, the provider is expected to accept full financial liability for the cost of the care. In addition, a waiver signed by a beneficiary after the care is rendered is not valid under TRICARE regulations. Health Net strongly recommends the use of the Request for Non-Covered Services form to ensure that the proper documentation is used to relieve the provider of full financial responsibility. A copy of this form can be found on the Health Net Web site at www.healthnetfederalservices.com.

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

- The agreement is documented prior to the specific non-covered services being rendered by using a Request for Non-Covered Services form.
- The agreement is in writing (a verbal agreement is not valid under TRICARE policy).
- The specific treatment, date(s), and estimated cost of service are documented.

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

Providers should be aware that there have been incidences when a TRICARE beneficiary has agreed to pay in full for non-covered services without signing a waiver. The provider rendered the care in good faith without prior authorization, and the beneficiary was not held responsible for payment. Without a signed waiver, the provider was denied reimbursement and could not bill the beneficiary.

Providers should maintain copies of the waiver in their office and fully inform beneficiaries in advance when specific services or procedures are not covered. See the Medical Coverage section of this handbook for a summary of TRICARE-covered and non-covered services and benefits.

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

Although a TRICARE-specific form is not required to document the payment agreement, it is important that non-network providers inform the beneficiary that he or she will be responsible for paying for a non-covered service. A written document listing the specific service(s) and cost(s) of the non-covered services identifying this agreement is recommended. Non-network providers can use the Request for Non-Covered Services form to document the payment agreement in writing prior to the service. A sample of this form may be downloaded from www.healthnetfederalservices.com.

**Updating Provider Information**

Keeping your information current helps provide accurate information to TRICARE providers and beneficiaries accessing the TRICARE provider directories (network and standard). Equally important—current information will help ensure that your referral and prior authorization requests are processed more quickly, your claims are appropriately paid, and payments are mailed to the correct address.

If you are a network provider, you may examine your listing and determine if the information is accurate by visiting Health Net’s Web site at www.healthnetfederalservices.com. Select “Provider” then click on the “Resources” tab.
From here, select “Update Provider Information” in the left column. This will take you to the Provider Directory where you will follow some easy steps to find and check your information. *(Not all network providers are listed in the directory, and information is subject to change without notice.)* You can also call 1-877-TRICARE (1-877-874-2273) to update your demographic information.

If you are a non-network provider, you are not listed in Health Net’s online network provider directory, but you may be listed in the TRICARE standard directory found on the TRICARE Web site at [www.tricare.mil/standardprovider](http://www.tricare.mil/standardprovider). You are also encouraged to update your demographic information by calling Health Net at 1-877-TRICARE (1-877-874-2273).

**Beneficiary Rights and Responsibilities**

**TRICARE Beneficiaries Have the Right to ...**

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

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

**Emergency Care:** Beneficiaries have the right to access emergency health care services when and where the need arises. They are not required to obtain prior authorization for care if they have reason to believe their life is in danger or they would be seriously injured or disabled without immediate care.

**Participate in Treatment:** Beneficiaries have the right to receive and review information about the diagnosis, treatment, and progress of their condition and to fully participate in all decisions related to their health care. If a beneficiary is unable to fully participate in treatment decisions, he or she has the right to be represented by family members, conservators, or other duly appointed representatives.

**Respect and Nondiscrimination:** Beneficiaries have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.

If a beneficiary is eligible for coverage under the terms and conditions of TRICARE or as required by law, he or she must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

**Confidentiality of Health Information:** Beneficiaries have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. They also have the right to review and copy their own medical records and request amendments to their records.

For more information about beneficiary rights, visit [www.tricare.mil/patientrights](http://www.tricare.mil/patientrights) or refer to the paper, *Safeguarding Beneficiaries’ Information*, also available on the Web site.

**TRICARE Beneficiaries Have the Responsibility to ...**

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

**Make Smart Health Care Decisions:** Beneficiaries have the responsibility to be involved in health care decisions, which means working with providers to develop and carry out agreed-upon treatment plans, disclosing relevant information, and clearly communicating wants and needs.
Be Knowledgeable about TRICARE:
Beneficiaries have the responsibility to be knowledgeable about TRICARE coverage and program options, including covered benefits, limitations, exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and appeals, claims, and grievance processes.

Beneficiaries also have the responsibility to:

- Show respect for other patients and health care workers
- Make a good-faith effort to meet financial obligations
- Use the disputed claims process when there is a disagreement
- Report wrongdoing and fraud to appropriate resources or legal authorities

In addition to the information above, note that TRICARE beneficiaries cannot be billed for the following charges:

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

TRICARE beneficiaries are required to pay the following charges:

- Copayments and cost-shares
- Deductibles
- Charges for non-covered services (if beneficiary has agreed in advance and in writing to pay for these services)
- All charges when a beneficiary is ineligible for TRICARE at the time of service

TRICARE Prime and TPR active duty family members do not have a copayment, cost-share, or deductible except for pharmacy copayments, POS cost-shares and deductibles, and TRICARE Extended Care Health Option cost-shares.
TRICARE Eligibility

TRICARE is available to eligible beneficiaries from any of the seven uniformed services—the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, the Commissioned Corps of the U.S. Public Health Service, and the Commissioned Corps of the National Oceanic and Atmospheric Administration. All eligible beneficiaries must register in the Defense Enrollment Eligibility Reporting System (DEERS).

How to Verify Eligibility

There are several identification (ID) and enrollment cards providers should be familiar with in order to verify a patient’s eligibility for TRICARE. Providers should ensure patients have a valid uniformed services ID card, Common Access Card (CAC), or authorization letter of eligibility. Be sure to check the expiration date and make a copy of both sides of the ID card for your files. (See “Copying ID Cards” later in this section.)

Note: An ID card alone is not sufficient to prove eligibility. Providers must verify the actual eligibility of the card bearer by accessing the Health Net Federal Services, LLC (Health Net) Web site at www.healthnetfederalservices.com or through the eligibility Interactive Voice Response (IVR) system, available by calling 1-877-TRICARE (1-877-874-2273). When verifying eligibility, be sure to use the sponsor’s Social Security number (SSN). If you are verifying online, retain a printout of the eligibility verification screen for your files.

Beneficiaries can verify their eligibility in DEERS by calling 1-800-538-9552. Providers, however, may not verify TRICARE enrollment directly in DEERS because of the Privacy Act (Title 5, United States Code, Section 552a).

Uniformed Services ID Cards

Common Access Card

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

Uniform Services ID Card

The Department of Defense (DoD), in conjunction with the seven uniformed services, began issuing the automated ID card in 1994.

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

- **Active duty family members (ADFMs):** DD Form 1173 (tan)
- **Family members of National Guard and Reserve members:** DD Form 1173-1 (red) if eligible for TRICARE Reserve Select (TRS) or when accompanied by a copy of the sponsor’s activation orders for more than 30 consecutive days
- **Retirees:** DD Form 2 RET (blue)
- **Retiree family members:** DD Form 1173 (tan) if eligible for TRICARE Reserve Select (TRS) or when accompanied by a copy of the sponsor’s activation orders for more than 30 consecutive days
- **Eligible members of the Transitional Assistance Management Program (TAMP):** DD Form 2765 (tan)

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

- **SSN or Sponsor SSN**—Providers should use the SSN when verifying the card bearer’s TRICARE eligibility.

Note: The DoD has begun to remove SSNs from ID cards. Providers must verify the beneficiary’s eligibility by contacting Health Net (as described earlier in this section).

- **Expiration Date**—Check the expiration date on the ID card in the box titled “EXPIRATION DATE” (should read “INDEF” for retirees). If expired, the beneficiary will need to update his or her information in DEERS and get a new card.
• **Civilian**—Check the back of the ID card to verify eligibility for TRICARE civilian care. The center section should read “YES” under the box titled, “CIVILIAN.” If a beneficiary using TRICARE For Life (TFL) has an ID card that reads “NO” in this block, they are still eligible to use TFL if they have Medicare Part A and Medicare Part B coverage.

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

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

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

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

**Copying ID Cards**

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

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

DoD recommends that providers copy both sides of the ID cards and retain copies for future reference.

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

**Important Notes about Eligibility**

Family members of ADSMs lose their eligibility at 12:00 a.m. on the day the active duty sponsor is discharged from service, unless they have extended benefits through TAMP.

ADSMs are normally enrolled in TRICARE Prime; however, TRICARE Prime enrollment is not the criteria for treating an ADSM. Once a member’s eligibility has been verified (as described previously in this section), care may be delivered and billed for payment. The service member’s branch of service provides for the care of ADSMs and is responsible for paying for any civilian emergency or referred health care required by ADSMs. DSM claims should be mailed to Health Net for processing. See the Claims Processing and Billing Information section of this handbook for additional details.

Members of the National Guard and Reserve not in a full-time active duty status may be shown as ineligible in DEERS. These members may be obtaining medical care as a result of a line-of-duty injury.

**Special Eligibility Rules under Diagnosis-Related Groups**

Under the TRICARE Standard diagnosis-related group (DRG) payment system, if a patient loses or gains eligibility during a hospitalization, the DRG hospital will be paid as if the patient were eligible during the entire admission. If the patient becomes entitled to Medicare Part A and Medicare Part B coverage, Medicare is the first payer and TRICARE becomes the secondary payer. For a patient who becomes eligible for Medicare because of age, and who is not an
ADFM, TRICARE’s secondary payer status is for that claim only. However, a change in eligibility often will affect outlier payments. The patient’s cost-share will be based on the status of the sponsor (active duty or retired) at the time of admission.

For all other providers, including DRG-exempt hospitals, TRICARE Standard will share the cost of only that portion of the services or supplies that was rendered before eligibility ceased.

**Entitlement to Medicare and TRICARE**

TRICARE beneficiaries who also are entitled to Medicare remain eligible for TRICARE as a secondary payer, provided they are entitled to Medicare Part A and have Medicare Part B coverage. There are two exceptions to this rule:

- ADFMs entitled to Medicare Part A do not have to purchase Medicare Part B coverage. However, once the sponsor retires, all Medicare-entitled family members, including the retired service member, must also be entitled to and have Medicare Part B coverage to retain TRICARE eligibility.
- Medicare beneficiaries enrolled in TRS or the US Family Health Plan (USFHP) are not required to have Medicare Part B coverage to retain coverage under these programs. However, DoD strongly encourages these beneficiaries to purchase Medicare Part B when initially eligible to avoid paying a 10-percent surcharge for each 12-month period that the beneficiary was eligible to enroll but did not.

When beneficiaries age 65 and older do not meet the eligibility requirements for Medicare Part A, they will need a Notice of Award or Notice of Disapproved Claim from the Social Security Administration to remain eligible for TRICARE.

In addition, beneficiaries under age 65 who have lost Medicare entitlement (for example, because they are declared no longer disabled) also need a formal Notice of Disapproved Claim from the Social Security Administration to remain eligible for TRICARE.

**Note:** The ADSM is covered by TRICARE even though he or she may be eligible for Medicare. Medicare does not terminate at the same time that Social Security disability payments terminate. Medicare may continue up to eight and a half years beyond the termination of Social Security disability payments. The beneficiary must continue to purchase Medicare Part B regardless of the termination of disability payments.

**Eligibility for TRICARE and Veterans Affairs Benefits**

In some cases, beneficiaries are eligible for benefits under both the TRICARE and Veterans Affairs (VA) programs. If a TRICARE beneficiary is also eligible for health care through VA, he or she has the option to use either TRICARE or VA benefits. Furthermore, TRICARE covers beneficiaries even if they received treatment through the VA for the same medical condition in a previous episode of care. However, TRICARE will not duplicate payments made by or authorized to be made by VA for treatment of a service-connected disability.

**Note:** Eligibility for health care through VA for a service-connected disability is not considered double coverage.
TRICARE’s family of programs offers comprehensive medical and dental benefits to every TRICARE beneficiary category. It is important to be aware of the choices available to beneficiaries.

TRICARE Prime

TRICARE Prime is a managed care option. TRICARE Prime enrollees receive most of their care from an assigned primary care manager (PCM) at a military treatment facility (MTF), if available, or from the TRICARE network. The PCM provides and coordinates care, maintains patient medical records, and refers patients to specialists, if necessary. Specialty care referred by the PCM may need to be arranged and approved by Health Net Federal Services, LLC (Health Net)/MHN, Inc. (MHN). See the Health Care Management and Administration section of this handbook for referral and authorization requirements. Primary, routine, and preventive care are provided by the assigned PCM unless the PCM issues a referral.

Eligibility for TRICARE Prime

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

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

TRICARE Prime Enrollment Card

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

In addition to their TRICARE Prime enrollment card, TRICARE Prime beneficiaries should present their uniformed services identification (ID) card or Common Access Card (CAC) at the time of service. Only the uniformed services ID card or CAC may be used to verify eligibility for care. Providers must verify eligibility via the Health Net Web site at www.healthnetfederalservices.com or through the eligibility Interactive Voice Response (IVR) system available by calling 1-877-TRICARE (1-877-874-2273). For more information about verifying eligibility, see the TRICARE Eligibility section of this handbook.

Primary Care Manager

TRICARE Prime enrollees are assigned a PCM who provides and coordinates care, maintains patient medical records, and refers patients to specialists, if necessary. According to TRICARE, a PCM who is practicing within the governing state’s rules and regulations may be a provider of primary care services when rendering services within a TRICARE Prime Service Area (PSA) location, or in those areas where the TRICARE Prime Remote (TPR) benefit is offered. This includes the following PCM types:

- Certified nurse midwives
- Family practitioners
- General practitioners
- Gynecologists
- Internal medicine physicians
- Nurse practitioners
- Obstetricians
A TRICARE Prime beneficiary relies on his or her PCM for referrals to specialty care providers and services either at an MTF or within the local network. PCMs may also need to obtain a referral from Health Net when required. For Health Net referral requirements, access the Referral Decision Tool online at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com). In addition, some services may require prior authorization. Use the Prior Authorization Determination Tool available through the Health Net Web site to determine prior authorization requirements. There is no requirement for a PCM referral and/or authorization for the following services:

- Those provided by the selected, assigned, or on-call PCM in his or her office
- The first eight visits for outpatient behavioral health care services provided by a network provider in a fiscal year (October 1–September 30) *(After the initial eight outpatient behavioral health care visits, prior authorization and medical necessity reviews are required.)*
- Emergency care
- Clinical preventive services from a TRICARE network provider *
- Services received while the beneficiary was using the point of service (POS) option

See the Important Provider Information section of this handbook for descriptions of specific PCM roles and responsibilities.

Health Net will assist with finding specialty care after a referral is requested. TRICARE Prime beneficiaries may be reimbursed for reasonable travel expenses for medically necessary care if Health Net authorizes a referral to a specialist who is located more than 100 miles away from their PCM’s office. TRICARE Prime enrollees are required to obtain all care from their PCM unless referred to another TRICARE-authorized provider. Beneficiaries will be referred to a TRICARE network provider based on availability per the TRICARE access standards. A referral to a non-network TRICARE-authorized provider will only occur if a TRICARE network provider is unavailable. Refer to the Health Care Management and Administration section of this handbook for more information about referrals and authorizations.

* Excludes ADSMs, who always need a referral to receive care outside of the MTF. Certain types of behavioral health care providers also always require a Letter of Referral (LOR). See the Behavioral Health Care Services section of this handbook for additional information.

**TRICARE Prime Point of Service Option**

A TRICARE Prime beneficiary who utilizes the POS option may self-refer to any TRICARE-authorized (network or non-network) provider for medical or surgical services without a referral from his or her PCM. For behavioral health care services, the POS option applies when the TRICARE Prime beneficiary receives nonemergency services from a non-network provider. Although a referral is not required when using the POS option, certain prior authorization requirements still apply.

The beneficiary will pay a deductible and 50 percent of the TRICARE-allowable charge. There is no catastrophic cap protection when using the POS option. Special considerations apply if the beneficiary has other health insurance (OHI). It is important to note the provider’s reimbursement remains unchanged, but the beneficiary will pay a larger portion of the total TRICARE-allowable charge. Also, it is important for providers to note the end date of referrals and to advise beneficiaries when additional referrals are required. For specific inpatient costs, contact Health Net at 1-877-TRICARE (1-877-874-2273) or visit the TRICARE Web site at [www.tricare.mil/costs](http://www.tricare.mil/costs).

**Note:** ADSMs may not use the POS option. ADSMs always need a referral to receive care outside of the MTF.

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

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

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

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

TPR and TPRADFM are offered only in the 50 United States, and both require enrollment with Health Net for participation within the North Region.

Accessing Health Care

Similar to TRICARE Prime, TPR and TPRADFM beneficiaries choose a PCM to provide primary care services and coordinate specialty care. In some cases, however, TPR and TPRADFM beneficiaries may have to choose a non-network TRICARE-authorized provider as their PCM if there are no network providers in their area. These beneficiaries can also receive services from military providers, if they are willing to travel to the MTF.

ADSMs can receive primary care services without a referral, prior authorization, or fitness-for-duty review. Specialty and inpatient care will require a referral and prior authorization from Health Net and the service point of contact (SPOC) at the Military Medical Support Office (MMSO). The SPOC will determine how to manage the referral if the care is related to fitness for duty.

Family members using TPRADFM may require a referral for specialty care and/or prior authorization for certain services from Health Net. Access the Referral Decision Tool and the Prior Authorization Determination Tool at www.healthnetfederalservices.com for Health Net referral and prior authorization requirements. Refer to the Health Care Management and Administration section of this handbook for additional information regarding referral and prior authorization requirements.

TPR Enrollment Card

Beneficiaries enrolled in TPR or TPRADFM receive TPR enrollment cards. Network providers may require beneficiaries to show the card at the time of service. These cards are not required to obtain care, but do contain important information for the beneficiary. Figure 4.2 shows an example of the TPR enrollment card.

TPR Enrollment Card

In addition to their TPR enrollment card, beneficiaries should present their uniformed services ID card at the time of service. Only the uniformed services ID card may be used to verify eligibility for care. Providers must verify eligibility through the Health Net Web site at www.healthnetfederalservices.com or the eligibility IVR system, available by calling 1-877-TRICARE (1-877-874-2273). See the TRICARE Eligibility section of this handbook for more information about verifying eligibility.

TPR/TPRADFM POS Option

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

**TRICARE Standard and TRICARE Extra**

TRICARE Standard and TRICARE Extra are available to all TRICARE-eligible beneficiaries except ADSMs. Beneficiaries are responsible for fiscal year deductibles and cost-shares. Beneficiaries may see any TRICARE-authorized provider they choose, and TRICARE will share the cost of covered services with the beneficiaries after deductibles are met.

TRICARE Standard is a fee-for-service option. Beneficiaries may seek care from any TRICARE-authorized provider.

TRICARE Extra is a preferred provider option. Beneficiaries choose a doctor, hospital, or other medical provider within the TRICARE provider network. By choosing a network provider, the beneficiary’s out-of-pocket costs are reduced. For specific inpatient cost-shares, contact Health Net at 1-877-TRICARE (1-877-874-2273) or visit www.tricare.mil/costs.

**TRICARE For Life**

TRICARE For Life (TFL) is TRICARE’s Medicare-wraparound coverage available worldwide to TRICARE beneficiaries regardless of age, provided they are entitled to premium-free Medicare Part A and also have Medicare Part B. TFL is available to all TRICARE/Medicare dual-eligible beneficiaries, including retired members of the National Guard and Reserve who are in receipt of retired pay, family members, widows/widowers, and certain former spouses. Dependent parents and parents-in-law are not eligible for TFL. TFL coverage is effective the same day that a beneficiary’s Medicare Part B coverage becomes effective.

**Note:** Beneficiaries age 65 and older who are not eligible for premium-free Medicare Part A remain eligible for TRICARE Prime and TRICARE Standard. Beneficiaries with only Medicare Part A or only Medicare Part B are not eligible for TFL. These beneficiaries may remain eligible for TRICARE Prime and TRICARE Standard, but only if they have an active duty sponsor. TRICARE/Medicare dual-eligible beneficiaries enrolled in the US Family Health Plan (USFHP) or TRICARE Reserve Select (TRS) are not required to have Medicare Part B coverage, but it is strongly recommended that they do so.

**How to Identify TFL Beneficiaries**

Each TFL beneficiary must present a valid uniformed services ID card, as well as a Medicare card, prior to receiving services. You should copy both sides of the cards and retain the copies for your files. There is no separate TFL enrollment card. To verify TFL eligibility, contact Wisconsin Physicians Service (WPS) at 1-866-773-0404. You may call the Social Security Administration at 1-800-772-1213 to confirm a patient’s Medicare status.

**Note:** If a beneficiary using TFL has an ID card that reads “NO” under the box titled “CIVILIAN,” he or she is still eligible to use TFL if he or she has Medicare Part A and Medicare Part B.

**How TFL Works**

The provider first files claims with Medicare. Medicare pays its portion and electronically forwards the claim to WPS, the TFL claims processor. WPS sends its payment for TRICARE-covered services directly to the provider. Beneficiaries receive a Medicare Summary Notice from Medicare and a TFL explanation of benefits (EOB) from WPS 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.
- For services covered by TRICARE but not by Medicare, such as care received overseas, Medicare pays nothing and TRICARE becomes the primary payer. The beneficiary is responsible for the TRICARE fiscal year deductible and cost-shares.
• For services covered by Medicare but not by TRICARE, such as chiropractic services, Medicare is the primary payer and TRICARE pays nothing. The beneficiary is responsible for the Medicare deductibles and cost-shares.
• For services not covered by Medicare or TRICARE, such as cosmetic surgery, the beneficiary is responsible for the entire bill.

How TFL Works with Other Health Insurance

TRICARE/Medicare beneficiaries with OHI, such as a Medicare supplement or employer-sponsored health plan, may also use TFL. By law, TRICARE pays claims only after any OHI plans have paid. Typically, after Medicare processes a claim, the claim is forwarded to the beneficiary’s OHI. Once the OHI processes the claim, the beneficiary will need to file a paper claim with TRICARE for any out-of-pocket expenses. TRICARE may reimburse the beneficiary for services covered by TRICARE.

TFL Referrals and Authorizations

Because Medicare is the primary payer, there is usually not a requirement for providers to obtain referrals or prior authorization from Health Net. If Medicare benefits are exhausted, or if the patient is seeking care covered by TRICARE but not Medicare, you may need an authorization from Health Net, when applicable. See the Health Care Management and Administration section of this handbook for services requiring a referral or authorization.

If you have questions about TFL, contact WPS at 1-866-773-0404 or visit the WPS Web site at www.TRICARE4u.com.

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

TRICARE Pharmacy Program

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

Medicare-eligible beneficiaries who turned 65 years of age after April 1, 2001, must enroll in Medicare Part B and ensure their Defense Enrollment Eligibility Reporting System (DEERS) profile is updated to use the TRICARE pharmacy benefit.

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

• MTF pharmacies (Formularies may vary by MTF pharmacy location. Contact your local MTF pharmacy to check availability.)
• Mail Order Pharmacy
  • 1-866-DoD-TMOP (1-866-363-8667) inside the United States
  • 1-866-ASK-4PEC (1-866-275-4732) outside the United States
• TRICARE retail network pharmacies
  • 1-866-DoD-TRRX (1-866-363-8779)
• Non-network pharmacies *

To have a prescription filled, beneficiaries will need a written prescription and a valid uniformed services ID card.

More information on the TRICARE Pharmacy Program is available at www.tricare.mil/pharmacy or www.express-scripts.com/TRICARE.

Note: After November 4, 2009, the phone number for both Mail Order Pharmacy and retail network pharmacy information is 1-877-363-1303.

* Filling prescriptions in non-network pharmacies is the most expensive option and is not recommended to beneficiaries.

Member Choice Center

TRICARE established the Member Choice Center (MCC) to assist TRICARE beneficiaries with transferring their retail pharmacy prescriptions to the Mail Order Pharmacy.

Additionally, military family members and retirees can use the MCC to update prescription information and receive answers to pharmacy questions. Beneficiaries may call the MCC at 1-877-363-1433 or access information online by visiting www.tricare.mil/pharmacy or www.express-scripts.com/TRICARE.
When TRICARE beneficiaries contact the MCC, an Express Scripts, Inc., patient-care advocate will verify their information and walk them through the conversion process. To help facilitate the process, the patient-care advocate may contact you to have your patient’s prescriptions transferred to the Mail Order Pharmacy.

**Generic Drug Use Policy**

It is a mandatory Department of Defense (DoD) policy to use generic-equivalent medications when available instead of brand-name medications. If a generic-equivalent drug does not exist, the brand-name drug will be dispensed at the brand-name cost.

**Prior Authorization for Brand-Name Medications**

Brand-name drugs that have a generic equivalent may be dispensed only if the prescribing physician is able to clinically justify the use of the brand-name drug in place of the generic equivalent. If you feel a brand-name medication (for which a generic equivalent is available) is clinically necessary, you must receive prior authorization before the patient can have the prescription filled at government expense. Otherwise, the beneficiary may be responsible for the entire cost of the medication. For prior authorization approval, call the TRICARE pharmacy contractor, Express Scripts, Inc., at 1-866-684-4488. **Note:** After November 4, 2009, call 1-877-363-1303.

**Uniform Formulary Drugs**

DoD has established a uniform formulary consisting of generic and brand-name drugs, as well as a third tier of medications that are designated as “non-formulary.”

Prescriptions for non-formulary drugs can be dispensed, but at a higher cost to beneficiaries (unless the prescribing physician can establish medical necessity).

For a complete list of non-formulary drugs, as well as the formulary medication alternative(s), visit www.tricare.mil/pharmacy/unif_form.cfm. The non-formulary list is normally updated on a quarterly basis.

**Section 4**

**Medical Necessity for Non-Formulary Medications (at Formulary Cost)**

A non-formulary medication can be provided at the formulary cost if the provider supplies information showing that there is a medical necessity to use the non-formulary medication instead of any of the therapeutic alternatives that are on the uniform formulary.

- **ADSMs:** If medical necessity is approved, ADSMs may receive non-formulary medications at retail network pharmacies and through the Mail Order Pharmacy at no cost.
- **All other eligible beneficiaries:** If medical necessity is approved, the beneficiary may receive the non-formulary medication at the formulary cost at retail network pharmacies and through the Mail Order Pharmacy.

In order for medical necessity to be established, one or more of the following criteria must be met for all of the available formulary alternatives:

- The 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.

To obtain medical necessity approval for a non-formulary medication, the provider will need to complete and submit a medical necessity form to Express Scripts, Inc.

**Prior Authorizations**

In addition to brand-name drugs with generic equivalents, the DoD Pharmacy and Therapeutics Committee has identified other medications that require prior authorization before they may be prescribed. For a complete list of these medications and for instructions on obtaining prior authorization, visit www.tricare.mil/pharmacy/prior_auth.cfm.
Step Therapy
Step therapy involves prescribing a safe, clinically effective, and cost-effective medication as the first step in treating a medical condition. The preferred medication is often a generic medication that offers the best overall value in terms of safety, effectiveness, and cost. Non-preferred drugs are only prescribed if the preferred medication is ineffective or poorly tolerated.

Drugs subject to step therapy will only be approved for first-time users after they have tried one of the preferred agents on the DoD Uniform Formulary. (Example: Currently, 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 when the drug became subject to step therapy, he or she will not be affected by step-therapy requirements and will not be required to switch medications.

For a complete list of medications subject to step therapy, see “Medications Identified by the Pharmacy and Therapeutics Committee” at www.tricare.mil/pharmacy/prior_auth.cfm.

Quantity Limits
DoD has established quantity limits for certain medications. Exceptions to established quantity or days’ supply limits can be made if you are able to justify medical necessity. Visit www.tricare.mil/pharmacy/quant_limits.cfm for a complete list of quantity limits for specific medications.

Forms
Prior authorization and medical necessity criteria and forms are accessible via the Formulary Search Tool Web site at www.tricareformularysearch.org. These forms apply only to prescriptions filled through retail network pharmacies or the Mail Order Pharmacy. MTF pharmacies may follow different procedures. At the top of each form, there is information on where to send the completed form. For assistance in completing prior authorization or medical necessity forms, call 1-866-684-4488. Note: After November 4, 2009, call 1-877-363-1303.

Pharmacy Costs
For information about TRICARE’s prescription drug coverage, visit www.tricare.mil/pharmacy or www.express-scripts.com/TRICARE.

Medicare Part D Coverage
Medicare Part D prescription drug coverage is available to everyone with Medicare Part A and/or Medicare Part B coverage, including Medicare-eligible TRICARE beneficiaries. However, Medicare-eligible TRICARE beneficiaries are not required to enroll in a Medicare Part D prescription plan to retain TRICARE eligibility.

You may direct eligible beneficiaries who inquire about Medicare Part D coverage to visit the TRICARE Web site at www.tricare.mil/medicarepartd. However, for the most up-to-date information on the Medicare Part D prescription drug benefit, beneficiaries should call Medicare at 1-800-MEDICARE (1-800-633-4227) or visit the Medicare Web site at www.medicare.gov.

Pharmacy Data Transaction Service
The Pharmacy Data Transaction Service (PDTS) creates a global centralized data repository that records information about prescriptions filled for DoD beneficiaries at MTFs and TRICARE retail network pharmacies, and through the Mail Order Pharmacy. PDTS improves the quality of prescription services and enhances patient safety by reducing the likelihood of adverse drug-drug interactions, therapeutic overlaps, and duplicate treatments across the highly transient population of active duty and retired beneficiaries.

PDTS conducts an online prospective drug utilization review (a clinical screening) against a beneficiary’s complete medication history for each new or refilled prescription in real time before it is dispensed to the patient. Regardless of where a beneficiary fills a prescription within the Military Health System, information about the prescription is stored in a robust central data repository and is available to authorized PDTS providers as a seamless enhancement to the
current workflow processes. Authorized PDTS providers include the Mail Order Pharmacy, MTF pharmacies, MTF providers, and all TRICARE retail network pharmacies.

**Mail Order Pharmacy Specialty Medication Prescription Service**

Specialty prescription medications are those high-cost injectable, oral, or inhaled drugs that a patient can self-administer. Effective November 4, 2009, TRICARE beneficiaries will be able to benefit from the Specialty Medication Care Management program when filling prescriptions for these medications through the Mail Order Pharmacy. Services include clinical assessments, refill reminders, beneficiary education, and side-effect management in order to improve safety and therapeutic outcomes.

Patients enrolled in this program have access to pharmacists 24 hours a day, seven days a week. The specialty clinical team will also reach out to the beneficiaries’ physicians, as needed, to address beneficiary issues, such as side effects or disease exacerbations. If any of your patients are currently having specialty medication prescriptions filled at a retail pharmacy, our specialty team will provide brochures detailing our specialty services as well as a prepopulated enrollment form.

If one of your patients requires specialty pharmacy medications, you may fax the prescription to the Mail Order Pharmacy from your office. The Mail Order Pharmacy will ship specialty medications to the beneficiary’s home. Faxed prescriptions must contain the following identification information in order to be processed: patient’s full name, date of birth, address, and ID number. Effective November 4, 2009, prescriptions should be faxed to 1-877-895-1900.

**Note:** Some specialty medications may not be available through the Mail Order Pharmacy because the medication’s manufacturer limits the drug’s distribution to specific pharmacies. If you submit a prescription for one of these limited-distribution medications, the Mail Order Pharmacy will either forward the prescription to a pharmacy that can fill it or will provide you with instructions about where to send the prescription to have it filled.


**Dental Programs Offered by TRICARE**

The TRICARE medical health care benefit covers only adjunctive dental care. For detailed information on adjunctive dental care coverage, see the *Medical Coverage* section.

The TRICARE health care benefit does not cover non-adjunctive dental care, which refers to any routine, diagnostic, preventive, restorative, prosthodontic, periodontic, endodontic, orthodontic, oral surgery, or emergency dental care that is not related to a medical condition. TRICARE beneficiaries may receive these dental services through MTFs and through one of three TRICARE dental programs—the TRICARE Active Duty Dental Program (ADDP), the TRICARE Dental Program (TDP), or the TRICARE Retiree Dental Program (TRDP)—if enrolled.

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

**TRICARE Active Duty Dental Program**

The ADDP is administered and underwritten by United Concordia Companies, Inc. (United Concordia) and provides civilian dental care to ADSMs through military dental treatment facilities (DTFs) located on base or sometimes co-located at an MTF. ADDP benefits are available to ADSMs who are either referred for care by a DTF to the civilian dental community or have a duty location and residence greater than 50 miles from a DTF. ADSMs enrolled in TPR are automatically eligible for the ADDP. For more information about the ADDP, visit [www.addp-ucci.com](http://www.addp-ucci.com) or [www.tricare.mil/dental](http://www.tricare.mil/dental).
**TRICARE Dental Program**

The TDP is a voluntary dental insurance program administered and underwritten by United Concordia that is available to eligible active duty family members (ADFM) and to National Guard and Reserve and Individual Ready Reserve members and their eligible family members. Active duty personnel (and National Guard and Reserve members called to active duty for a period of more than 30 consecutive days or eligible for the pre-activation benefit up to 90 days prior to their report date) are not eligible for the TDP. They receive dental care through the ADDP. Former spouses, parents, parents-in-law, disabled veterans, foreign military personnel, and uniformed services retirees and their families are not eligible for the TDP. Additional information about TDP benefits, requirements, and restrictions can be found online at [www.TRICAREdentalprogram.com](http://www.TRICAREdentalprogram.com).

**TRICARE Retiree Dental Program**

The TRDP is a voluntary dental insurance program administered and underwritten by the Federal Services division of Delta Dental of California (Delta Dental). The TRDP offers comprehensive, cost-effective dental coverage for uniformed services retirees and their eligible family members, as well as certain surviving family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors. Other details of TRDP benefits, requirements, and restrictions can be found on the Delta Dental TRDP Web site at [www.trdp.org](http://www.trdp.org).

**TRICARE for the National Guard and Reserve**

The seven National Guard and Reserve components include:

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

**Line-of-Duty Care for National Guard and Reserve Members**

A line-of-duty (LOD) condition is determined by the military service and includes any injury, illness, or disease incurred or aggravated while the National Guard and Reserve member is in a duty status, either inactive duty (such as reserve drill) or active duty. This includes the time period when members are traveling directly to or from the place where they perform military duty. National Guard and Reserve members will receive written authorization that specifies the LOD condition and terms of coverage. *Note:* DEERS will 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)
- Coverage under the TRS health program option

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

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

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

Coverage When Activated for More than 30 Consecutive Days
When National Guard and Reserve members are called to active duty for more than 30 consecutive days, they become eligible for TRICARE. They are considered ADSMs and may enroll in TRICARE Prime or TPR, according to local policy, once they reach their final duty station.

Family members of these 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. If eligible, family members may access care with TRICARE Prime, TPRADFM, TRICARE Standard, or TRICARE Extra health care program options, as well as dental coverage through the TDP. Sponsors are required to register their family members in DEERS.

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

TRICARE Reserve Select
TRS is a premium-based health plan offered by DoD that provides comprehensive health care coverage to members of the National Guard and Reserve who meet specific eligibility requirements.

Verifying TRS Coverage
After purchasing TRS, each member and covered family member receives a TRS enrollment card. You should make a photocopy of the front and back of the card for your files. Providers must contact Health Net through the TRS toll-free customer service number at 1-800-555-2605 to verify coverage status.

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

Prior Authorizations and Referrals
TRS members may access care from any TRICARE-authorized provider, network or non-network, without a referral.
TRICARE requires prior authorization* for certain services, e.g., inpatient admissions for substance use disorders or behavioral health, adjunctive dental care, home health services, hospice care, transplants, psychoanalysis, and psychotherapy after the initial eight behavioral health care outpatient visits.

See the Health Care Management and Administration section of this handbook for more information.

* Refer to the Prior Authorization Determination Tool on the Health Net Web site at www.healthnetfederalservices.com for services that require prior authorization.

Claims and Reimbursement

See the Claims Processing and Billing Information section of this handbook or visit www.healthnetfederalservices.com for details about filing TRS claims.

For More Information

- Call Health Net at 1-800-555-2605.

Cancer Clinical Trials

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

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

There are three types of NCI clinical trials:

- **Phase I trials:** Phase I trials, which are primarily concerned with assessing a drug’s safety, are not covered currently by TRICARE due to their highly experimental nature.

- **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 a promising new treatment against the standard approach. These studies also focus on a particular type of cancer.

Cost of Participation

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

- The provider seeking treatment for a TRICARE-eligible beneficiary in an NCI-approved protocol has obtained prior authorization for the proposed treatment before initial evaluation.

- The treatments are NCI-sponsored Phase II or Phase III protocols.

- The patient continues to meet entry criteria for the protocol.

- The institutional and individual providers are TRICARE-authorized providers.

How to Participate

Prior authorization is required to participate in an NCI clinical trial. The Cancer Clinical Trials Coordinator for the TRICARE North Region can be reached at 1-800-395-7821 from 8 a.m. to 5 p.m. Eastern Time. Be sure to contact the coordinator before beginning the evaluation or any treatment under the clinical trial.
The NCI Web site at [www.cancer.gov](http://www.cancer.gov) lists some of the Phase II and Phase III NCI-sponsored clinical trials, but not all of them. To determine if there are clinical trials available, contact the Cancer Clinical Trials Coordinator for the TRICARE North Region at 1-800-395-7821.

**TRICARE Extended Care Health Option**

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

Potential ECHO beneficiaries must be ADFMs, have a qualifying condition, and be registered to receive ECHO benefits. A record of ECHO registration is stored with a beneficiary’s DEERS information.

Conditions qualifying an ADFM for TRICARE ECHO coverage include:

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

TRICARE providers, especially PCMs, are responsible for managing care for TRICARE beneficiaries. Any TRICARE provider (PCM or specialist) can inform the patient’s sponsor about the ECHO benefit. Beneficiaries should be referred to Health Net 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.

**Note:** Active duty sponsors with family members seeking ECHO registration must enroll in their service’s Exceptional Family Member Program (EFMP) and register for ECHO in order to be eligible for ECHO benefits. There is no retroactive registration into the ECHO program.

Prior authorization must be obtained from Health Net for all care provided under the ECHO program or providers run the risk of having ECHO claims denied.

**ECHO Provider Responsibilities**

- Providers may be requested to provide medical records or assist beneficiaries with completing EFMP documents.
- Network and participating providers must submit ECHO claims to WPS.
- A provider rendering applied behavior analysis (ABA) must be a TRICARE-certified provider that meets one of the following criteria:
  - Has a current state license to provide ABA services
  - Is certified by the Behavior Analyst Certification Board as either a Board Certified Behavior Analyst or Board Certified Associate Behavior Analyst
  
  **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
- Providers must obtain prior authorization for all ECHO services.

TRICARE can pay for the “hands on” ABA services when provided by a TRICARE-certified provider. However, TRICARE will not pay for such services when provided by family members, trainers, or other individuals who are not TRICARE-certified providers.
**ECHO Benefits**

Coverage through the TRICARE basic programs may not be sufficient for those eligible beneficiaries with qualifying needs. TRICARE ECHO provides the following additional benefits for these beneficiaries.

**ECHO Basic Benefits**

- Medical, habilitative, and rehabilitative services
- Training to use assistive technology devices
- Special education, including ABA therapy and Educational Interventions for Autism Spectrum Disorders (EIA) services through the Enhanced Access to Autism Services Demonstration
- Institutional care when a residential environment is required
- Transportation under certain limited circumstances, i.e., to receive an authorized ECHO benefit; also includes coverage for a medical attendant when needed to ensure safe transport of the beneficiary
- Assistive services, when needed to receive an authorized ECHO benefit, such as those from a qualified interpreter or translator
- Durable equipment (e.g., electrical or mechanical lifting device for a wheelchair-bound beneficiary)
- ECHO respite care—16 hours per month to provide relief for primary caregivers*

**ECHO Home Health Care Benefits**

- Expanded respite care and in-home medically necessary skilled services through TRICARE ECHO Home Health Care (EHHC)
- EHHC respite care—up to eight hours per day, five days per week to provide relief for the primary caregivers to allow them rest/sleep*
- EHHC provides homebound beneficiaries requiring skilled, extended in-home health care services that are:
  - Not limited to part-time or intermittent
  - Capped by cost, not by hours (using the skilled nursing facility reimbursement rate)

For more information regarding the EHHC, refer to Chapter 9, Section 15.1 of the TRICARE Policy Manual at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil).

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

**ECHO Costs**

Effective October 14, 2008, the government’s maximum cost-share for certain ECHO services is $36,000 per fiscal year. Services included in this change are:

- Assistive technology devices
- Institutional care
- Limited transportation to and from institutions or facilities
- Rehabilitation
- Special education (which can include ABA)
- Training

An ECHO maximum monthly cost-share of $2,500 applies to services provided under Sections 6.1, 7.1 (excluding rehabilitation), 12.1, 13.1, and 14.1 of the TRICARE Policy Manual, and accrues to the fiscal year maximum cost-share:

- Assistive services
- Diagnostic services
- Durable equipment
- ECHO respite care
- Treatment (excluding rehabilitation)

Maximum cost-share limits under ECHO are per beneficiary, regardless of the number of dependents with the same sponsor receiving ECHO benefits in that period.

Costs for EHHC services do not accrue to the monthly or fiscal year government maximum cost-shares.
Cost-shares under ECHO are in addition to those incurred for services provided under the basic TRICARE benefit (e.g., TRICARE Prime, TRADFM, TRICARE Standard, TRICARE Extra). **Note:** ECHO sponsor/beneficiary cost-shares do not accrue toward the catastrophic cap.

**Prior Authorizations**

Refer to the Health Care Management and Administration section of this handbook for details on ECHO prior authorizations for the North Region.

**Claims**

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

**For More Information**

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

- Health Net Federal Services, LLC
- 1-877-TRICARE (1-877-874-2273)
- www.healthnetfederalservices.com
- ECHO Web site
- www.tricare.mil/echo
- EFMP information
- www.militaryhomefront.dod.mil/efm

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**DoD Enhanced Access to Autism Services Demonstration**

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

- If there is increased access to these services
- If the services are reaching those most likely to benefit from them

- If the quality of those services is meeting an appropriate standard of care currently accepted by the professional community of providers, including the Behavioral Analyst Certification Board
- That state licensure and certification requirements, where applicable, are being met

The Enhanced Access to Autism Services Demonstration allows non-certified educational intervention service providers, or tutors, to provide autism services to military family members in the United States. The demonstration is effective for services provided on or after March 15, 2008. Health Net will administer the enhanced autism services in the TRICARE North Region.

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

**Note:** The allowed cost of services provided by the Enhanced Access to Autism Services Demonstration on or after October 14, 2008, accrue to the ECHO fiscal year government maximum cost-share. See “TRICARE Extended Care Health Option” earlier in this section for details.


**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 LOD conditions. While the SHCP is also funded by DoD, it is separate from TRICARE and follows different rules. Only the individuals listed below are eligible for the SHCP:

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

To verify SHCP patient eligibility, call Health Net at 1-877-TRICARE (1-877-874-2273).

### Civilian Care

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

### Referrals and Authorizations

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

See the Claims Processing and Billing Information section for SHCP claims submission information.

### Transitional Health Care Benefits

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

#### Continued Health Care Benefit Program

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

DoD has contracted with Humana Military Healthcare Services, Inc. (Humana Military) to administer the CHCBP. Humana Military issues beneficiaries a CHCBP ID card (shown in Figures 4.5 and 4.6 on the following page) after enrollment is completed.

This card is different from a uniformed services ID card or a CAC, which may no longer be valid. All questions regarding CHCBP eligibility verification can be addressed through Humana Military’s Web site at www.humana-military.com or by calling 1-800-444-5445.

**Note:** Health Net is unable to provide assistance with CHCBP inquiries. You must contact Humana Military.
CHCBP Coverage

The benefits available under CHCBP are similar to TRICARE Standard, and although it is not part of TRICARE Standard, it operates under most of the same rules. When providing care, the main differences to remember are that, under CHCBP, providers are not required to utilize or coordinate with MTFs, and nonavailability statements from an MTF are no longer required. These differences exist because a CHCBP beneficiary is no longer eligible to receive military care or use MTFs (except in the case of emergency care).

Referrals and Authorizations

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

Phone: 1-800-444-5445
Fax: 1-877-270-9113

Humana Military has partnered with PGBA, LLC (PGBA) for CHCBP claims processing. See the Claims Processing and Billing Information section for more information about filing CHCBP claims.

Transitional Assistance Management Program

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

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

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

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

In this section, the TRICARE-covered services are highlighted and specific details about some of the more complex benefits are included. This section is not intended to be all-inclusive.

For additional information or specific questions about TRICARE-covered services, contact Health Net Federal Services, LLC (Health Net) at 1-877-TRICARE (1-877-874-2273), visit www.healthnetfederalservices.com, or review the TRICARE Policy Manual, the TRICARE Reimbursement Manual, and the TRICARE Operations Manual online at http://manuals.tricare.osd.mil. You can also review the TRICARE Provider News publication for regular articles about benefits and program changes.

Some military treatment facilities (MTFs) may offer services or procedures that are not covered by TRICARE. Beneficiaries should contact their local MTF for more information about these services. Additionally, the Military Medical Support Office (MMSO) may authorize services for active duty service members (ADSMs) that are not regular TRICARE benefits. As long as the advance authorization is in place, providers will be paid accordingly.

Covered Services

TRICARE covers individual provider services such as routine office visits; outpatient office-based medical and ambulatory (same-day) surgical care; consultation, diagnosis, and treatment by a specialist; allergy tests and treatment; osteopathic manipulation (except for chiropractic care); rehabilitation services, e.g., physical therapy, speech pathology services, and occupational therapy; and medical supplies used within the office, including casts, dressings, and splints. Also included are certain diagnostic radiology and ultrasound, diagnostic nuclear medicine, pathology and laboratory services, and cardiovascular studies.

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

TRICARE covers inpatient services, as long as they are medically necessary. Hospitalization is covered in a semi-private room (or in special care units when medically necessary) and includes general nursing, hospital service, inpatient physician and surgical services; meals, including special diets; drugs and medications during an inpatient stay; operating and recovery room; anesthesia; laboratory tests; X-rays and other radiology services; necessary medical supplies and appliances; and blood and blood products.

The services listed below will be discussed in more detail:

- Adjunctive dental care
- Ambulance services
- Clinical preventive services
- Durable medical equipment (DME)
- Emergency care
- Home health care
- Hospice care
- Maternity care
- Skilled nursing facility (SNF) care
- Urgent care
- Vision care

Inpatient and outpatient behavioral health care is also covered. See the Behavioral Health Care Services section of this handbook for details about covered behavioral health care services.
Adjunctive Dental Care

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

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

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

The TRICARE health care benefit does not cover non-adjunctive dental care, which refers to any routine, preventive, restorative, prosthodontic, periodontic, or emergency dental care that is not related to a medical condition. TRICARE may, however, cover medically necessary institutional and general anesthesia services in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental, or physical disabilities or for pediatric patients age 5 or younger. TRICARE beneficiaries may receive these dental services through military dental treatment facilities and through one of three TRICARE dental programs—the TRICARE Active Duty Dental Program, the TRICARE Dental Program, or the TRICARE Retiree Dental Program—if enrolled. Refer to the TRICARE Program Options section for TRICARE Dental Program information.

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

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

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

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

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

All adjunctive dental care requires prior authorization. Prior authorization will determine if a beneficiary’s condition requires adjunctive or non-adjunctive dental care. The prior authorization requirement is waived only when essential adjunctive dental care involves a medical emergency, such as facial injuries resulting from a car accident.

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

Ambulance Services

TRICARE covers ambulance services for the following conditions:

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

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

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

TRICARE does not cover ambulance services for these conditions:

- Nonemergency ambulance services used instead of a taxi service or other normal transportation means when the patient’s condition would permit use of regular transportation

Note: This is a benefit under the TRICARE Extended Care Health Option (ECHO) program when the beneficiary is being transported for ECHO services, but only if ambulance transport is required to ensure the beneficiary’s safety.

- Transport or transfer of a patient primarily for the purpose of having the patient closer to home, family, friends, or a physician

- Any type of medicabs or ambicabs that function as public passenger services transporting patients to and from medical appointments

For additional information about ambulance services, refer to Chapter 8, Section 1.1 of the TRICARE Policy Manual. For additional information about emergency services, refer to Chapter 2, Section 6.1 of the TRICARE Policy Manual at http://manuals.tricare.osd.mil.

Clinical Preventive Services

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

Cancer Screenings

- Colonoscopy—Individuals at average risk for colon cancer are covered once every 10 years beginning at age 50. For individuals at increased risk for colon cancer, these are the recommended age ranges and frequencies:

1. Hereditary non-polyposis colorectal cancer syndrome: Colonoscopy should be performed every two years beginning at age 25, or five years younger than the earliest age of diagnosis of colorectal cancer in an affected
relative, whichever is earlier. Annual screening should be performed after age 40.

2. **Familial risk of sporadic colorectal cancer:** For first-degree relatives with sporadic colorectal cancer or adenomas before the age of 60, or multiple first-degree relatives with colorectal cancer or adenomas, colonoscopy should be performed every three to five years beginning 10 years earlier than the youngest affected relative.

**Note:** Computed tomographic colonography (CTC) is covered as a colorectal cancer screening only when an optical colonoscopy is medically contraindicated or cannot be completed due to a known colonic lesion or structural abnormality, or when other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is not covered as a colorectal cancer screening for any other indication or reason.

- **Fecal Occult Blood Testing**—Test annually starting at age 50.

- **Mammograms**—Perform annually for those over age 39. If your patient is at high risk for breast cancer, a baseline mammogram is appropriate at age 35, then annually thereafter. Asymptomatic TRICARE Prime beneficiaries age 30 or older, and asymptomatic TRICARE Standard beneficiaries age 35 or older, can receive a breast magnetic resonance imaging (MRI) scan annually as a screening procedure if they are considered at high risk of developing breast cancer by American Cancer Society guidelines. The guidelines include women with a:
  1. BRCA1 or BRCA2 gene mutation
  2. First-degree relative (parent, child, or sibling) with a BRCA1 or BRCA2 gene mutation
  3. Lifetime risk approximately 20 percent to 25 percent or greater as defined by BRCAPRO or other models that are largely dependent on family history
  4. History of chest radiation between age 10 and age 30
  5. History of Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with one of these syndromes

- **Physical Examination for Colorectal Cancer**—Digital rectal examination should be included in the periodic health examination of individuals 40 years of age and older.

- **Proctosigmoidoscopy or Sigmoidoscopy**—Once every three to five years beginning at age 50.

- **Prostate Cancer**—Digital rectal examination and prostate-specific antigen screening annually for all men in the following categories:
  1. Age 50 or older
  2. Age 45 or older with a family history of prostate cancer in at least one other family member
  3. All African-American men age 45 or older regardless of family history
  4. Age 40 and older with a family history of prostate cancer in two or more other family members

- **Routine Pap Smears**—Annually starting at age 18 (or younger if sexually active). Frequency may be less often at your and the patient’s discretion, but not less than every three years.

- **Skin Cancer**—Exams may be sought at any age by individuals at high risk with a family history or increased sun exposure.

**Cardiovascular**

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

**Clinical Preventive Exams**

- **TRICARE Standard**—A comprehensive clinical preventive exam is covered if it includes or is rendered at the same time as a covered immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening. Clinical preventive exam claims usually include a general medical examination diagnosis (V70 or V70.0). A separate diagnosis code for an immunization, screening Pap smear, screening mammogram, colon cancer screening, or prostate cancer screening is required for claims payment. See the individual screening services for frequency of coverage. School enrollment physicals for children ages 5–11 years are covered. Annual sports physicals are excluded.

- **TRICARE Prime**—In addition to the above, TRICARE Prime beneficiaries in each of the following age groups may receive one comprehensive clinical preventive exam without an accompanying immunization, Pap
smear, mammogram, colon cancer screening, or prostate cancer screening (one exam per age group): 2–4, 5–11, 12–17, 18–39, and 40–64 years. While often rendered by a PCM, clinical preventive exams and accompanying immunization and screenings may be performed by any network provider without a referral. For screening Pap smears, mammograms, or colonoscopies, see the individual services for frequency of coverage.

**Hearing**

Preventive hearing examinations are only allowed under the well-child care benefit. Preventive hearing screenings are also covered for all high-risk neonates as defined by the Joint Committee on Infant Hearing. A newborn audiology screening should be performed on high-risk newborns prior to hospital discharge or within the first three months using evoked otacoustic emission (EOE) and/or auditory brainstem response (ABR) testing. Evaluative hearing tests may be performed at other ages during routine exams.

**Human Papillomavirus Vaccine**

The human papillomavirus (HPV) vaccine was developed to prevent cervical cancer. Effective October 1, 2006, the vaccine is covered by TRICARE. TRICARE follows the Centers for Disease Control and Prevention (CDC) guidelines. The CDC recommends the vaccine for all females aged 11–26 years who have not completed the vaccine series, regardless of sexual activity or clinical evidence of previous HPV infection. Ideally, the vaccination should be given before potential exposure to HPV through sexual activity and may be given as early as age 9 years. After the age of 26, no efficacy has been established; therefore, it is not a covered benefit. Routine HPV screening is not covered.

**Immunizations**

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

- The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP)
- The ACIP-adopted recommendations have been accepted by the Director of the CDC and the Secretary of Health and Human Services and published in a *CDC Morbidity and Mortality Weekly Report (MMWR)*.

TRICARE coverage is effective the date the recommendations are published in the *MMWR*.

Refer to the CDC’s Web site at [www.cdc.gov](http://www.cdc.gov) for a current schedule of recommended vaccines.

**Note:** Immunizations required for active duty family members (ADFMs) whose sponsors have permanent change-of-station orders to overseas locations are covered as an outpatient office visit.

TRICARE covers age-appropriate doses of annual influenza vaccines based on the current influenza season CDC guidelines. Beneficiaries using TRICARE Standard or TRICARE Extra have the same coverage for the vaccine as those enrolled in TRICARE Prime, TPR, or TPRADFM.

**Infectious Disease Screening**

Covered screenings for infectious diseases include hepatitis B, rubella antibodies and HIV, and screening and/or prophylaxis for tetanus, rabies, Rh immune globulin, hepatitis A and B, meningococcal meningitis, and tuberculosis. Routine HPV screening is not covered.

**Patient/Parent Education**

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

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

**Shingles Vaccine**

Effective October 19, 2007, TRICARE covers a single dose of the shingles vaccine Zostavax® for beneficiaries age 60 and older per CDC
recommended guidelines. Beneficiaries must have vaccinations administered in a provider’s office. Zostavax is covered under the TRICARE medical benefit and is not reimbursable under TRICARE’s pharmacy benefit.

**Vision**

See “Vision Care” later in this section for details about clinical preventive eye examinations.

**Well-Child Care**

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

**Lead Exposure Testing**

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

**Note:** Annual sports physicals are not a covered benefit under TRICARE.

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

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

With TRICARE Prime:

- TRICARE Prime offers enhanced vision coverage. *(See “Vision Care” later in this section for more details.)*
- TRICARE Prime enrollees do not need a referral or prior authorization for clinical preventive services.*
- There is no copayment when care is received from a TRICARE network provider.

When using TRICARE Standard or TRICARE Extra:

- Preventive vision coverage is not included after age 6. *(See “Vision Care” later in this section for details.)*
- Beneficiaries using TRICARE Standard or TRICARE Extra may have clinical preventive services performed by a TRICARE-authorized network or non-network provider.
- Cost-shares and deductibles may apply for some services.

For more information about clinical preventive services that TRICARE covers, refer to Chapter 7, Sections 2.1–2.2 of the *TRICARE Policy Manual* at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil).

*ADSMs must have a referral and prior authorization before receiving clinical preventive services, except for those enrolled in TPR when care is rendered by their PCM.*

**Durable Medical Equipment**

DME refers to medical equipment or supplies that your patient will need in order to arrest or reduce functional loss.

**Prior Authorization for DME**

- **TRICARE Standard**—No authorization is required for TRICARE-covered DME (including capped rental items); however, a certificate of medical necessity (CMN) may be required.
- **TRICARE Prime**—Authorization is required for the purchase of DME greater than or equal to $2,000 per item. All DME categorized by the Centers for Medicare and Medicaid Services as “capped rentals” requires an authorization.

Access the Prior Authorization Determination Tool at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com) for DME prior authorization requirements.

**Certificate of Medical Necessity for DME**

For DME where authorization is not required or not obtained, the submitting provider will need to obtain a CMN for all rentals or purchases greater than $150.
A CMN is required for DME when:

- For TRICARE Standard beneficiaries, the DME has a purchase price greater than $150.
- For TRICARE Prime beneficiaries, the DME has a purchase price greater than $150, but less than $2,000. (For TRICARE Prime beneficiaries, DME with a purchase price of $2,000 or greater requires prior authorization.)
- The DME is a rental (except for capped rental items for TRICARE Prime beneficiaries, in which case prior authorization is required).

CMNs may be faxed without a cover sheet to Health Net’s secure fax line at 1-888-432-7077. Multiple CMNs should be submitted separately.

The CMN should include the following information:

- Sponsor’s Social Security number
- Patient’s name
- Diagnosis
- Patient’s date of birth
- CMN date and length of time DME is required
- Description of DME, including procedure codes, and any special features or accessories
- Provider’s signature and credentials (All CMNs must be signed by a physician, i.e., M.D. or D.O.)

While faxing is preferred, you may also mail CMN correspondence to:

Health Net Federal Services, LLC
c/o PGBA, LLC/TRICARE
P.O. Box 870141
Surfside Beach, SC 29587-9741

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

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

Emergency 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 existed 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 should be considered.

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.

Notify Health Net In Case of Emergency Admissions (TRICARE Prime, TPR, and TPRADFM Only)

In all emergency situations, a TRICARE Prime beneficiary must notify his or her PCM or Health Net of any emergency inpatient admission within 24 hours or the next business day so that ongoing care can be coordinated.

Within 24 hours or the next business day, TRICARE providers should notify Health Net of an emergency room inpatient admission by faxing the patient’s hospital admission record “face sheet” to Health Net at 1-888-299-4181. The hospital admission record face sheet should include the beneficiary’s demographic information, health plan information, name of the admitting physician, and the admitting diagnosis and date. If the hospital admission record face sheet is not available, providers can also complete a TRICARE Service Request/Notification Form and fax it to 1-888-299-4181. Be sure to note on the form that the information is for an emergency inpatient admission notification.

Once the hospital admission record face sheet is received by Health Net, a Health Net medical management representative will contact the hospital at the time of notification to obtain clinical information and discuss discharge planning. The
representative will also provide his or her name and telephone number to the hospital for follow-up contacts. Once the clinical information is received, a tracking number and an “average length of stay” goal will be issued. A confirmation letter with this information will be mailed or faxed to the hospital.

For a smooth transition from the hospital for the beneficiary, Health Net requires the hospital to directly notify their Health Net medical management representative as soon as the discharge plan and date have been established or, at a minimum, 24 hours (one business day) prior to discharge. An authorization number, which confirms the coverage of the hospital day(s) from the time of admission to discharge, will be provided upon the hospital’s notification to Health Net of the discharge date.

During the course of the hospital stay, if it is determined that care is no longer medically necessary or if requested clinical information is not received, Health Net will issue a denial letter no less than 24 hours in advance of the effective date of the denied coverage.

**Home Health Care**

TRICARE’s home health care benefits are similar to those covered under Medicare. They provide a maximum of 28 hours per week part-time, or 35 hours per week intermittent, skilled nursing care and physical, speech, and occupational therapy. All care must be provided by a participating home health care agency. The home health care plan is designed to provide a more complete array of coverage, including:

- Physical, speech, or occupational therapy
- Physician-directed medical social services
- Routine and non-routine medical supplies
- Services at hospitals when the care involves equipment that cannot be brought into the home

It is important to note that assistance with activities of daily living (washing laundry, cleaning dishes, etc.) is not part of the home health care benefit. While the home health care professional may provide some assistance with basic daily living care, these tasks are considered ancillary and are not his or her primary duties while in the patient’s home.


For home health care benefits related to the TRICARE ECHO program, refer to Chapter 9, Section 15.1 of the TRICARE Policy Manual at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil).

**Respite Care for Active Duty Service Members**

Effective September 18, 2008, TRICARE covers respite care for ADSMs who are homebound as a result of a serious injury or illness incurred while serving on active duty. The benefit is retroactive to January 1, 2008, and provides rest for the primary caregiver caring for an injured or ill ADSM at home.

Respite care is available if the ADSM’s plan of care includes frequent interventions by the primary caregiver. “Frequent” means that more than two interventions are required during the eight-hour period per day that the primary caregiver would normally be sleeping.

Respite benefits are limited to:

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

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

The respite care must be provided by a TRICARE-authorized home health agency and requires prior authorization from Health Net and the ADSM’s approving authority, such as the MMSO or referring MTF. The ADSM is not required to be enrolled in the TRICARE ECHO program to receive this respite benefit.

For additional details on the respite care benefit for ADSMs, refer to Chapter 18, Section 3 and Chapter 18, Addendum C of the TRICARE Operations Manual at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil).
Hospice Care

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

Initiating Hospice Care

The patient, the PCM, or a family member acting on the patient’s behalf can initiate hospice care, but the hospice will not begin services without a doctor’s order. Patients must complete an “election statement,” which the hospice provides, that indicates their understanding of what hospice care involves. This statement is then filed with Health Net. Patients must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) to be eligible for and initiate hospice care. No authorization is required for a hospice evaluation. If the patient does not meet criteria for admission for hospice services, the provider cannot bill TRICARE. If the beneficiary qualifies for and decides to receive hospice services, the hospice should request prior authorization from Health Net as soon as possible.

Hospice care is provided in three benefit periods. The first two benefit periods are each 90 days long and begin on the day that a hospice election statement is signed by the beneficiary and a physician’s certificate of terminal illness is signed by both the attending physician and the hospice medical director. The final benefit period comprises an unlimited number of 60-day periods, each of which requires recertification of the terminal illness. If a beneficiary revokes a hospice election, he or she forfeits any remaining days in that election period.

There are four levels of care within the hospice benefit:

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

Levels of care will be determined by the Medicare-certified hospice agency. One of these levels of care will be in use at all times, and patients can shift among all four, depending on their needs and the needs of family members who are supporting them. Care within these 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.

Once patients elect hospice care, their care is managed by the medical director of the hospice and by the interdisciplinary clinical team managing the case, always in consultation with patients and their families. PCMs may stay involved and participate in the clinical team, as well as manage any acute needs outside hospice coverage.

Because hospice care emphasizes supportive services, such as pain control and home care, rather than cure-oriented treatment, 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, like a broken bone or unrelated diabetes, are still covered as a regular TRICARE benefit.

Exclusions

There is no reimbursement for room-and-board charges for a patient who is receiving hospice services in the home. Room and board is not a covered hospice benefit when a patient is placed in a facility such as a rest home and the care is custodial. Patients also cannot receive other TRICARE services/benefits (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 provides it or arranges for it.

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, he or she forfeits the
remaining days in the election period, but at any time may elect to receive hospice coverage for any other hospice election periods for which he or she is eligible. The patient receiving hospice services may transfer from one hospice provider to another hospice provider only one time during each election period.

**Hospice Care Settings**

Hospice care can be provided in a number of settings: at home, in a hospice facility, in an SNF, or in an MTF. Care can shift among these settings without affecting the hospice benefit or requiring an additional hospice authorization. Inpatient respite care may be available at an appropriate hospice location and is considered part of the hospice benefit for up to five days on an occasional basis.

**Note:** There are no deductibles under the hospice benefit. The individual hospice may charge a cost-share for those items not allowed by the TRICARE program, such as medications, biologicals, and/or inpatient respite care.


**Maternity Care**

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

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

**Referrals and Authorizations**

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

If your patient is enrolled in TRICARE Prime and intends to deliver in a civilian (non-MTF) facility or birthing center, a separate prior authorization for the delivery portion of her maternity care must be obtained. The separate prior authorization should be obtained as soon as her pregnancy is confirmed.

Additional prior authorization is required for the following maternity-related services:

- Maternity inpatient stays (length of stay cannot be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section)
- Planned cesarean section and tubal ligation

**Covered Services**

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

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

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

TRICARE Maternity-Related Ultrasounds

The professional and technical components of medically necessary fetal ultrasounds are covered in addition to the maternity global fee. Per American College of Obstetricians and Gynecologists (ACOG) guidelines, ultrasonography should be performed only when there is a valid medical indication. A physician is not obligated to perform ultrasonography for a patient who is at low risk and has no medical indications. Some providers offer all patients routine ultrasound screening as part of the scope of care after 16–20 weeks of gestation. TRICARE does not cover routine ultrasound screening. Only maternity ultrasound with a valid medical indication that constitutes medical necessity is covered by TRICARE.

Clinical circumstances that substantiate medical necessity include, but are not limited to:

- Unknown date of last menstrual period, irregular periods, size-date different by greater than 2 weeks, or pregnancy while on oral contraceptive pills preventing estimation of gestational age without an ultrasound
- Fundal height growth significantly greater than expected (more than 1 cm per week) or less than expected (less than 1 cm per week), requiring evaluation of fetal growth
- Chronic maternal diseases (insulin-dependent diabetes mellitus), hypertension, systemic lupus, congenital heart disease, chronic renal disease, hyperthyroidism, prior pregnancy with unexplained fetal demise, multiple gestations, post-term pregnancy after 41 weeks, intrauterine growth retardation, oligo- or polyhydramnios, preeclampsia, decreased fetal movement, and/or isoimmunization (These conditions would provide medical necessity to conduct a biophysical evaluation for fetal well-being.)
- Evaluation of a suspected ectopic pregnancy
- Determination of the cause of vaginal bleeding
- Diagnosis or evaluation of multiple births
- Heart rate not detectable by Doppler when it should be heard and/or suspected fetal demise; therefore, necessary to confirm cardiac activity
- Evaluate maternal pelvic masses or uterine abnormalities
- Evaluate suspected hydatidiform mole
- Evaluate the fetus’ condition in late registrants for prenatal care

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

Non-Medically Necessary Maternity Ultrasounds

Ultrasounds that do not have a valid medical indication are not covered by TRICARE, and payment may be the beneficiary’s responsibility. For example, an ultrasound to determine gestational age or evaluation for fetal well-being without a clinical circumstance substantiating medical necessity would not be covered. If the beneficiary and the rendering ultrasound provider agree to perform an ultrasound that is not considered medically necessary, the
ultrasound provider may only bill the beneficiary directly under certain conditions. For more information, see “Informing Beneficiaries about Non-Covered Services” under “Provider Responsibilities” in the Important Provider Information section of this handbook.


**Skilled Nursing Facility Care**

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

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


**Urgent Care**

Urgent care services are medically necessary services that are required for illness or injury that would not result in further disability or death if not treated immediately. However, this type of illness/injury does require professional attention and has the potential to develop into such a threat if treatment is delayed longer than 24 hours. An urgent care condition could be a sprain, sore throat, or rising temperature. Beneficiaries enrolled in TRICARE Prime, TPR, and TPRADFM should receive urgent care from their assigned PCM unless they have a referral.

**Vision Care**

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

TRICARE’s vision coverage varies based on beneficiary category and program options.

**Active Duty Service Members**

TRICARE Prime ADSMs must receive all vision care at an MTF unless specifically referred to a network provider, or to a non-network provider if a network provider is not available. TPR ADSMs may obtain a comprehensive eye examination from a network provider as needed to maintain fitness-for-duty status without an authorization.

**Active Duty Family Members**

ADFMs are covered for one eye examination annually, regardless of their program option (TRICARE Prime, TRICARE Standard and TRICARE Extra, etc.).

**Retired Service Members, Family Members, and Others**

Retired service members, their families, and others who are enrolled in TRICARE Prime are covered for eye examinations under TRICARE Prime’s clinical preventive services benefit. See Figure 5.1 on the following page for coverage details.

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

Vision care coverage is provided under the TRICARE well-child benefit for all TRICARE-eligible infants and children up to age 6, regardless of program option. See Figure 5.2 for coverage details.

Eyeglasses, Contact Lenses, and Implantable Lenses

ADSMs are covered for eyeglasses at MTFs at no cost. To obtain eyeglasses or contact lenses outside of the MTF, ADSMs should contact the Naval Ophthalmic Support and Training Activity (NOSTRA) via their Web site at http://nostra.norfolk.navy.mil or by phone at 1-757-887-7611.

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

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

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

Other

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

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

For more information about TRICARE’s vision coverage, refer to Chapter 7, Sections 2.1 and 2.2 of the TRICARE Policy Manual at http://manuals.tricare.osd.mil.

Limitations and Exclusions

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

Contact Health Net or visit the Web site at www.healthnetfederalservices.com for more information.
Services or Procedures with Significant Limitations

The following listed services are covered with significant limitations:

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

Botox® Injections—Excluded for cosmetic procedures, myofacial pain, fibromyalgia, and headaches. Limited in use for treatment of blepharospasm resulting in visual disturbance. May be covered in other circumstances, such as for the treatment of dystonias and muscle spasticity condition. **Note:** Botox B (Myobloc®) is only indicated for treatment of cervical dystonia.

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 with a physician-documented medical reason, such as the inability to breastfeed. This documentation is also required for premature infants delivered in non-hospital settings.

Breast pumps of any type, when used for reasons of personal convenience (e.g., to facilitate a mother’s return to work), are excluded even if prescribed by a physician. Manual breast pumps (E0602) and basic (non-hospital grade) electric pumps (E0603) are also excluded.

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

Chiropractic Care—Coverage is limited to ADSMs and is only available at specific MTFs under the Chiropractic Care Program. For more information, visit the TRICARE Web site at www.tricare.mil/chiropractic.

Clinical Preventive Examinations—A comprehensive clinical preventive exam is covered if it includes or is rendered at the same time as a covered immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening. Clinical preventive exam claims usually include a general medical examination diagnosis (V70 or V70.0). School enrollment physicals for children ages 5–11 are covered. Annual sports physicals are excluded.

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

Cranial Orthotic Device or Molding Helmet—Cranial orthotic devices are listed on the No Government Pay Procedure Code List for all conditions.

Dental Anesthesia and Facility Charges—Medically necessary institutional and general anesthesia services may be covered to safeguard a patient’s life or in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental, or physical disabilities or for pediatric patients age 5 or younger.

Dental Care and Dental X-Rays—Both are covered only for adjunctive dental care.

Diagnostic Genetic Testing—Diagnostic genetic testing is covered only when conducted to confirm a clinical diagnosis that is already suspected based on patient’s symptoms. Refer to the *TRICARE Policy Manual*, Chapter 6, Section 3.1. For antepartum services, refer to the *TRICARE Policy Manual*, Chapter 4, Section 18.2.
**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®, as evidenced by a Certificate of Recognition.

**Eyeglasses or Contact Lenses**—See “Vision Care” earlier in this section.

**Food, Food Substitutes or Supplements, or Vitamins Outside of a Hospital Setting**—These are covered only for home enteral or parenteral nutrition therapy, such as when prescribed for cancer patients.

**Gastric Bypass**—Gastric bypass is covered for individuals who are 100 pounds (or more) over their ideal body weight with comorbidity, and for those who are 200 percent or more of their ideal body weight (in which case comorbidity is not required).

**Note:** Effective and retroactive to February 1, 2007, laparoscopic adjustable gastric banding (Lap-Band® surgery) is covered for eligible TRICARE beneficiaries. For more information on surgery for morbid obesity, refer to the TRICARE Policy Manual, Chapter 4, Section 13.2 at http://manuals.tricare.osd.mil.

**Genetic Testing**—Genetic testing is only covered under certain conditions.

**Hearing Aids**—Hearing aids are covered for ADFMs who meet specific criteria. Hearing aids are not covered for retired service members, their families, or others.

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

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**Exclusions**

The following services are excluded under any circumstance:

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

Health Net Federal Services, LLC (Health Net) manages the behavioral health care benefit and MHN, Inc. (MHN) manages the network of behavioral health care providers for TRICARE beneficiaries in the North Region. The behavioral health care outpatient network consists of licensed outpatient providers, such as psychiatrists and other physicians, psychologists, social workers, marriage and family therapists, certified psychiatric nurse specialists, licensed or certified mental health counselors, and pastoral counselors.

If the provider is a licensed or certified mental health counselor or pastoral counselor, a physician referral and supervision are required. Document this information in the patient’s medical record, and indicate it in Box 17/17a/17b on the CMS-1500 claim form. Physician referral means that a physician actually sees the patient, performs an evaluation, and arrives at an initial diagnostic impression prior to referring the patient. The physician provides overall medication management and receives regular communication concerning treatment of the plan.

There is an additional requirement for licensed or certified mental health counselors and pastoral counselors. By indicating the referring physician in Box 17/17a/17b of each claim, the licensed or certified mental health counselor or pastoral counselor is also certifying that written communication of the treatment results has been (or will be) made to the referring physician. Such communication should be made at the end of the treatment or more frequently, as required by the referring physician (see 32 Code of Federal Regulations [CFR] 199.7). This is a statutory and regulatory TRICARE program requirement.

The behavioral health care inpatient network consists of hospitals, inpatient psychiatric units, partial hospitalization programs (PHPs), residential treatment centers (RTCs), and substance use disorder rehabilitation facilities (SUDRFs). Behavioral health care network providers are required to comply with all other provider responsibilities as identified in the Important Provider Information section of this handbook.

Health Net reviews clinical information to determine medical or psychological necessity. In certain circumstances, the TRICARE behavioral health care services benefit limits may be waived if the services are determined to be medically or psychologically necessary.

TRICARE beneficiaries are encouraged to receive behavioral health care from a military treatment facility (MTF). However, access to an MTF may be limited due to space-availability issues or the MTF’s ability to render the care needed. When a service is not available at an MTF, beneficiaries will be referred to a network provider. Benefits are payable for services when rendered in the diagnosis or treatment of a covered behavioral health disorder by an authorized, qualified behavioral health care provider practicing within the scope of his or her license.

Referral and Authorization Requirements

To determine if a Health Net referral is required, providers can access the Referral Decision Tool under the “Authorizations” tab on the Provider Portal at www.healthnetfederalservices.com. Using the tool, select the beneficiary’s TRICARE program option and primary care manager (PCM) type (if a TRICARE Prime program option beneficiary), enter the beneficiary’s home ZIP code, and select “Submit.” The tool will process your entry then indicate whether Health Net requires a referral.

If a referral from Health Net is necessary, you may submit your request online at www.healthnetfederalservices.com. Providers who are unable to submit requests online can use the TRICARE Service Request/Notification Form and submit the request via fax to 1-888-299-4181. You may find the form at www.healthnetfederalservices.com or request one by calling Health Net at 1-877-TRICARE (1-877-873-2273).

If care cannot be provided at the MTF, Health Net will assist in identifying services within the civilian network.
Health Net prior authorization requirements are listed on the following pages for each beneficiary category. In addition to these requirements, note that Health Net does not require prior authorization for emergency behavioral health inpatient admissions when referred by an evaluating physician (M.D. or D.O.). Health Net will authorize emergency behavioral health care for up to 72 hours without clinical review. However, Health Net requires notification within 24 hours of the admission or the next business day for all TRICARE beneficiaries, except those eligible for TRICARE and Medicare, and TRICARE For Life (TFL) beneficiaries. Providers can also use the Prior Authorization Determination Tool at www.healthnetfederalservices.com to determine if a Health Net prior authorization is required. Claims submitted by network providers without a prior authorization number may be subject to a 10-percent penalty of the negotiated rate.

Active Duty Service Members

Active duty service members (ADSMs) must receive behavioral health care services at an MTF when available. ADSMs must have a referral from their PCM and prior authorization from Health Net to seek any nonemergency behavioral health care services from a civilian network or non-network provider. TRICARE Prime Remote (TPR) ADSMs may receive civilian behavioral health care with a prior authorization from Health Net and their service point of contact (SPOC).

Note: Prior authorization is not required for emergency behavioral health care inpatient admissions when referred by an evaluating physician (M.D. or D.O.); however, the admitting facility must notify MHN within 24 hours of admission.

Beneficiaries Using TRICARE Prime and TRICARE Prime Remote for Active Duty Family Members

Beneficiaries enrolled in TRICARE Prime (except for ADSMs) or TRICARE Prime Remote for Active Duty Family Members (TPRADFM) may receive the first eight outpatient visits per fiscal year (October 1–September 30) from a TRICARE network provider without a referral or prior authorization, unless services are provided by a licensed or certified mental health counselor or pastoral counselor, in which case a physician referral and supervision are required. Providers do not need to “register” care or obtain a referral from Health Net to document the initial eight outpatient visits. Claims for these visits will be processed without a Health Net referral.

After the first eight self-referred outpatient visits, prior authorization is required. In addition, the following psychiatric services require prior authorization:

- All nonemergency inpatient admissions for substance use disorder or behavioral health care. Note: Behavioral health care inpatient admissions require notification to Health Net within 24 hours of admission or the next business day.
- Psychotherapy after the first eight self-referred outpatient visits. Note: One initial evaluation per beneficiary per year is allowed without prior authorization. The initial evaluation does not count toward the first eight self-referred outpatient visits.
- Psychoanalysis
- PHPs and RTC programs

Behavioral Health Care Provider Locator and Appointment Assistance Line

TRICARE and Health Net have established the Behavioral Health Care Provider Locator and Appointment Assistance Line to help eligible ADSMs and active duty family members (ADFM) find behavioral health care providers and schedule timely appointments for urgent and routine outpatient behavioral health care.

This service is available to all ADSMs and ADFMs enrolled in TRICARE Prime, TPR, or TPRADFM, as well as ADFMs enrolled in an overseas TRICARE Prime program option who have temporarily returned to the United States. Prior to calling the appointment assistance line, ADSMs must have a referral from their MTF PCM, SPOC, or their MTF behavioral health care clinic for civilian behavioral health care.

Note: ADSMs calling this service without an appropriate referral or authorization will only be provided with MTF points of contact.
ADFMs not enrolled in a TRICARE Prime program option, retired service members, their families, and others should be referred to Health Net’s general TRICARE toll-free telephone line at 1-877-TRICARE (1-877-873-2273) for behavioral health care assistance.

TRICARE Prime access standards for urgent and routine medical care apply to all behavioral health care services, including appointments made through the appointment assistance line. The wait time for an initial urgent behavioral health care appointment shall generally not exceed 24 hours. The wait time for an initial routine behavioral health care appointment shall not exceed one week. Following the initial appointment, the behavioral health care provider’s medical judgment will determine the wait time for the beneficiary’s follow-up appointments.

Health Net manages the North Region Behavioral Health Care Provider Locator and Appointment Assistance Line. The dedicated toll-free number, 1-877-747-9579, is available from 8 a.m. to 6 p.m. Eastern Time (7 a.m. to 5 p.m. Central Time), Monday through Friday, excluding federal holidays.

**Note:** This appointment assistance line is **not** a crisis intervention line. Direct all TRICARE beneficiaries seeking emergency behavioral health care assistance to call 911 or to proceed to the nearest emergency room for treatment.

### Beneficiaries Using TRICARE Standard, TRICARE Extra, or TRICARE Reserve Select

Beneficiaries using TRICARE Standard, TRICARE Extra, or TRICARE Reserve Select (TRS) can receive the first eight outpatient visits without prior authorization. Services provided by a licensed or certified mental health counselor or pastoral counselor require a physician referral and supervision.

After the first eight self-referred outpatient visits, prior authorization is required. In addition, the following psychiatric services require prior authorization:

- All nonemergency inpatient admissions for substance use disorder or behavioral health care. **Note:** Behavioral health inpatient admissions require notification to Health Net within 24 hours of admission or the next business day.
- Psychotherapy after the initial eight self-referred outpatient visits
- Psychoanalysis
- PHPs and RTC programs

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

### Beneficiaries Using Medicare and TRICARE

Beneficiaries using Medicare as their primary payer and TRICARE as secondary payer (TFL) are not required to obtain referrals or prior authorization from Health Net for inpatient or outpatient behavioral health care services. These beneficiaries should follow Medicare rules for services requiring authorization. They may self-refer to any network or non-network provider who accepts Medicare. When behavioral health care benefits are exhausted under Medicare, TRICARE becomes the primary payer, and prior authorization from Health Net is then required.

### Nonavailability Statements

A nonavailability statement (NAS) is required for all nonemergency behavioral health care admissions. An NAS is a certification from an MTF stating that it cannot provide a specific required service at a particular time to a non-enrolled (i.e., non-TRICARE Prime) beneficiary.

Providers should advise TRICARE beneficiaries to check with the beneficiary counseling and assistance coordinator at the local MTF to find out if an NAS is required before obtaining nonemergency behavioral health care inpatient services. An NAS does not take the place of an authorization for those services requiring prior authorization.
Outpatient Services

Outpatient Psychotherapy

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

- Individual psychotherapy (session not to exceed 60 minutes but may extend to 120 minutes for crisis intervention)
- Family or conjoint psychotherapy (session not to exceed 90 minutes but may extend to 180 minutes for crisis intervention)
- Group psychotherapy (session not to exceed 90 minutes)
- Crisis intervention (individual psychotherapy session not to exceed 120 minutes; family or conjoint psychotherapy session not to exceed 180 minutes)
- Collateral visits
- Psychoanalysis

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

- The benefit year for TRICARE program options (e.g., TRICARE Prime, TRICARE Standard, TRICARE Extra, TRS) is based on the fiscal year (October 1–September 30).
- A provider cannot bill for more than two sessions per calendar week (Sunday–Saturday) without prior authorization.
- Two psychotherapy sessions may not be combined to circumvent the frequency limitation criteria (e.g., 30 minutes on one day may not be added to 20 minutes on another day and counted as one session).
- 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.

Psychological and Neuropsychological Testing

Psychological testing must be medically necessary. There must be either a diagnosis or provisional diagnosis of a behavioral health disorder, and the testing must be appropriate for the diagnosis.

Psychological testing and assessment is generally approved up to six hours in a fiscal year. However, additional hours may be approved in special circumstances on a case-by-case basis.

TRICARE does not cover the following psychological and neuropsychological testing:

- Reitan-Indiana battery test when administered to beneficiaries under age 5 or when self-administered by beneficiaries under age 13
- Assessment for academic placement, including all psychological testing related to educational programs, issues, or deficiencies
- Testing to determine a learning disability, if the primary or sole basis for the testing is to assess for a learning disability
- Testing in conjunction with child custody disputes or job placement
- General screening (in the absence of specific symptoms of a covered behavioral health disorder) to determine if the individual being tested is suffering from a behavioral health disorder
- Teacher or parental referrals for psychological testing
- Diagnosing specific learning disorders or learning disabilities encompassing a reading disorder (e.g., dyslexia), mathematics disorder, disorder of written expression, or learning disorder not otherwise specified

Medication Management

Medication management is covered when provided as an independent procedure and rendered by a TRICARE-authorized provider practicing within the scope of his or her license. Medication management does not require prior authorization.
When a provider is performing medication management along with therapy, a prior authorization is required, unless these services are administered as part of the patient’s first eight self-referred outpatient visits for the fiscal year.

**Electroconvulsive Therapy**
Electroconvulsive therapy is covered when determined to be medically necessary.

**Inpatient Services**

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

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

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

**Acute Inpatient Care**
The purpose of acute inpatient care is to stabilize a life-threatening or severely disabling behavioral health condition. TRICARE defines a psychiatric emergency admission as “an admission when, based on a psychiatric evaluation performed by a physician (or other qualified behavioral health care provider with hospital admission authority), the beneficiary is at immediate risk of serious harm to self or others as a result of a behavioral health disorder and requires immediate continuous skilled observation at the acute level of care.”

In a life-threatening situation, the provider should direct the beneficiary to the closest appropriate health care facility or emergency room. If an MTF is geographically available, referral to the MTF emergency room is an appropriate option.

The beneficiary’s age at the time of admission determines the actual number of benefit days that can be authorized for acute inpatient care per fiscal year (*October 1–September 30*). The limits are as follows:

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

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

Health Net does not require prior authorization for TRICARE emergency behavioral health admissions. Health Net will authorize emergency behavioral health care for up to 72 hours without clinical review. However, Health Net requires notification from the provider within 24 hours of the admission. This applies to any eligible ADSM or TRICARE beneficiary when referred by an evaluating physician (*M.D. or D.O.*). Providers can use the TRICARE Service Request/Notification Form and submit their requests by fax to **1-888-299-4181**. You may access the form at **www.healthnetfederalservices.com**.

After receipt of notification of the admission, the behavioral health care provider will be contacted by an associate from Health Net to coordinate ongoing patient care. Administrative payment reduction may be applied to the days prior to the receipt of notification.

**Psychiatric Partial Hospitalization Programs**
A psychiatric PHP provides an appropriate setting for crisis stabilization or treatment of partially stabilized behavioral health disorders and serves as a transition from an inpatient program when medically necessary.

In order for Health Net to authorize services at a psychiatric PHP, the program must be TRICARE-authorized by the National Quality
Monitoring Contractor (NQMC), MAXIMUS, Inc. (MAXIMUS). PHPs that are interested in becoming TRICARE-authorized providers may contact MAXIMUS by any of the following means:

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<thead>
<tr>
<th>Mail</th>
<th>NQMC—MAXIMUS 1600 E. Northern Avenue Suite 100 Phoenix, AZ 85020</th>
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</thead>
<tbody>
<tr>
<td>Phone</td>
<td>1-602-308-7160</td>
</tr>
<tr>
<td>E-mail</td>
<td><a href="mailto:nqmc@maximus.com">nqmc@maximus.com</a></td>
</tr>
</tbody>
</table>

Additionally, psychiatric PHP facilities must be capable of providing an interdisciplinary program of medically therapeutic services at least three hours per day, up to five days per week, including day, evening, or weekend treatment.

- Prior authorization is required for all PHP admissions, without exception.
- PHP care is limited to a maximum of 60 treatment days (whether a full-day or half-day program) in a fiscal year (October 1–September 30) or for any single admission. The limit may be waived if the treatment is determined to be medically necessary.
- The 60 PHP treatment days are not offset by, nor counted toward, the inpatient limit of 30 days for beneficiaries age 19 years and older or 45 days for beneficiaries age 18 years and younger.

**Filing Claims for PHP Charges**

Psychological testing conducted while a beneficiary is in an approved PHP will be considered included in the facility’s per diem rate. PHP care must be billed on a UB-04.

- Revenue Code 912—Psychiatric Partial Hospitalization, all-inclusive per diem payment of three to five hours (half day)
- Revenue Code 913—Psychiatric Partial Hospitalization, all-inclusive per diem payment of six or more hours (full day)

Effective May 1, 2009, the TRICARE outpatient prospective payment system (OPPS) pays claims filed for hospital outpatient services, including hospital-based PHPs (psychiatric and SUDRFs) subject to TRICARE’s prior authorization requirements. Freestanding PHPs (psychiatric and SUDRFs) will continue to be reimbursed under the existing PHP per diem payment, as stated in Chapter 7, Section 2 of the TRICARE Reimbursement Manual, available online at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil). TRICARE OPPS is mandatory for both network and non-network providers.

TRICARE has adopted Medicare’s reimbursement methodology for hospital-based PHPs. There are two separate Ambulatory Payment Classification (APC) payment rates under this reimbursement methodology:

- **APC 0172:** For days with three services
- **APC 0173:** For days with four or more services

Additionally, TRICARE allows physicians, clinical psychologists, clinical nurse specialists, nurse practitioners, and physician assistants to bill separately for their professional services delivered in an OPPS hospital-based PHP. The professional services that are included in the PHP per diem payment are those furnished by clinical social workers, occupational therapists, alcohol and addiction counselors, and providers employed or contracted by a non-OPPS facility.

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

For more information about how OPPS affects TRICARE PHPs, refer to the TRICARE Reimbursement Manual, Chapter 13, Section 2 at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil), or contact Health Net’s toll-free customer service line at 1-877-TRICARE (1-877-874-2273). Refer to the TRICARE Reimbursement Methodologies section in this handbook for additional OPPS reimbursement details.
Residential Treatment Centers

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

All RTCs must be TRICARE-authorized by the NQMC, MAXIMUS, to provide residential treatment to TRICARE-eligible beneficiaries.

Providers may contact MAXIMUS by any of the following means:

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<tr>
<th>Mail</th>
<th>NQMC—MAXIMUS</th>
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<tbody>
<tr>
<td></td>
<td>1600 E. Northern Avenue</td>
</tr>
<tr>
<td></td>
<td>Suite 100</td>
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<tr>
<td></td>
<td>Phoenix, AZ 85020</td>
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<tr>
<td>Phone</td>
<td>1-602-308-7160</td>
</tr>
<tr>
<td>E-mail</td>
<td><a href="mailto:nqmc@maximus.com">nqmc@maximus.com</a></td>
</tr>
</tbody>
</table>

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

Additional RTC details include:

- Prior authorization is required, without exception.
- RTC care is covered to a maximum of 150 days in a fiscal year or for a single admission, if medically necessary. These limits are subject to waiver in certain cases.
- Concurrent reviews are conducted during the course of the RTC stay.

TRICARE reimbursement for RTC care is 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 the 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 will be covered only in cases when appropriate education is not available from or not payable by local, state, or federal governments. TRICARE is always the payer of last resort. For network providers, this coverage limitation applies only if educational services are not part of the contracted per diem rate.
- Non-behavioral health care services—Services provided to the beneficiary not related to behavioral health care, such as medical treatments for asthma or diabetes, may be reimbursed separately from the RTC.

Alcoholism and Other Substance Use Disorders

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

Outpatient Care for Alcoholism or Other Substance Use Disorders

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

Non-facility-based outpatient services are not a covered benefit for a beneficiary with a primary diagnosis of substance use disorder/dependence in an office-based setting.

Waivers to the limits on care can be granted in special circumstances if the continued care meets certain requirements. This is true of both inpatient care and partial hospitalization.

Detoxification

Detoxification services are covered when medically necessary for the active medical treatment of the acute phases of substance use withdrawal (detoxification), for stabilization, and for the treatment of medical complications of substance use disorders. Emergency and inpatient hospital...
services are considered medically necessary only when the patient’s condition is such that the personnel and facilities of a hospital are required.

Coverage details include:

- Covered for up to seven days per episode in a TRICARE-authorized facility, if medically necessary
- Counts toward the maximum of 30 or 45 days (depending on the patient’s age) of inpatient behavioral health care allowed per fiscal year
- Does not count toward the 21 days of rehabilitation mentioned in the following section, “Substance Use Rehabilitation”

**Substance Use Rehabilitation**

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

The following details apply to substance use rehabilitation:

- Prior authorization is required for rehabilitation stays, without exception.
- Care is covered for up to 21 days of rehabilitation per benefit period in a TRICARE-authorized facility (includes inpatient and partial hospitalization days or a combination of both).
- Coverage is subject to the following limits:
  - One treatment episode in a one-year benefit period
  - Three treatment episodes during a person’s lifetime
- An inpatient rehabilitation stay counts toward the 30- or 45-day limit of inpatient behavioral health care allowed per fiscal year.
- A partial hospitalization rehabilitation stay counts toward the 60-day psychiatric partial hospitalization limit.
- TRICARE shares the cost of this partial hospitalization rehabilitation treatment for up to 21 days at a predetermined, all-inclusive per diem rate.

**Court-Ordered Care**

Court-ordered care is defined by TRICARE as medical services, including inpatient admissions, that a party in a legal proceeding is ordered or directed to obtain by a court of law. The fact that behavioral health care services are ordered by a court for a TRICARE-eligible beneficiary does not determine the benefits available under TRICARE. TRICARE benefits are paid only if the services are medically or psychologically necessary to diagnose and/or treat a covered condition. The services must be at the appropriate level of care to treat the condition, and the beneficiary (or family) must have a legal obligation to pay for the services.

**Non-Covered Behavioral Health Care Services**

The following behavioral health care services are not covered under TRICARE. This list is not intended to be all-inclusive.

- Aversion therapy (including electric shock and the use of chemicals for alcoholism, except for Antabuse® [disulfiram], which is covered for the treatment of alcoholism)
- Behavioral health care services and supplies related solely to obesity and/or weight reduction
- Bioenergetic therapy
- Biofeedback for psychosomatic conditions
- Carbon dioxide therapy
- Counseling services that are not medically necessary in the treatment of a diagnosed medical condition, e.g., educational counseling, vocational counseling, nutritional counseling, stress management, marital therapy, or lifestyle modifications
- Custodial nursing care
- Diagnostic admissions
- Educational programs
- Environmental ecological treatments
- Experimental procedures
- Eye movement desensitization and reprocessing (EMDR)
- Filial therapy
- Guided imagery
- Hemodialysis for schizophrenia
- Intensive outpatient treatment program
- Marathon therapy
- Megavitamin or orthomolecular therapy
- Narcotherapy with LSD
• Primal therapy
• Psychosurgery (Surgery for the relief of movement disorders, electroshock treatments, and surgery to interrupt the transmission of pain along sensory pathways are not considered psychosurgery.)
• Rolfing
• Sedative action electrostimulation therapy
• Services and supplies related to “stop smoking” regimens
• Services and supplies that are not medically or psychologically necessary for the diagnosis and treatment of a covered condition
• Services for V-code diagnoses
• Sexual dysfunction therapy (see “Sexual Disorders” later in this section)
• Surgery performed primarily for psychological reasons (such as psychogenic)
• Telephone counseling (except for geographically distant family therapy related to RTC treatment)
• Therapy for developmental disorders such as dyslexia, developmental mathematics disorders, developmental language disorders, and developmental articulation disorders
• Training analysis
• Transcendental meditation
• Unproven drugs, devices, and medical treatments or procedures
• Vagus nerve stimulation (VNS) therapy
• Z therapy

**Sexual Disorders**

Sexual dysfunction is characterized by disturbances in sexual desire and by the psychophysiological changes that characterize the sexual response cycle, causing marked distress and interpersonal difficulties. Any therapy, service, or supply provided in connection with sexual dysfunction or inadequacies is excluded from TRICARE coverage. Exclusions include therapy, services, or supplies for these disorders/dysfunctions:

• Gender identity disorders—characterized by strong and persistent cross-gender identification accompanied by persistent discomfort with one’s assigned gender

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

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

Behavioral Health Care Outpatient Services: Coverage Details

<table>
<thead>
<tr>
<th>Behavioral Health Evaluation and Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Benefits provide up to two routine therapy sessions per week; more frequent visits require additional authorization.</td>
</tr>
<tr>
<td>• Each beneficiary (except ADSMs) may self-refer for the first eight outpatient therapy sessions per fiscal year without a medical necessity review or prior authorization; sessions beyond the initial self-referred eight require a medical necessity review and prior authorization. ADSMs must follow the protocol within their MTF for obtaining behavioral health care within the MTF. For care outside of the MTF, ADSMs must have a referral from their PCM or, if enrolled in TPR, from SPOC.</td>
</tr>
</tbody>
</table>

Notes:
• Routine outpatient behavioral health care visits do not require a PCM referral; beneficiaries may self-refer. (ADSMs must follow procedures as noted above.)
• Licensed or certified mental health counselors or pastoral counselors require a physician referral and ongoing supervision with the referring physician in order to be paid. The referral and supervision do not have to be from the beneficiary’s PCM. This information must be included on the CMS-1500 claim form in blocks #17 and #19. A copy of the referral should be kept in the patient’s chart.
• One initial evaluation per beneficiary, per fiscal year is allowed without prior authorization. The initial evaluation does not count toward the first eight self-referred outpatient therapy sessions available to non-ADSMs.
• Crisis intervention always requires authorization; request as soon as possible after services are rendered.

<table>
<thead>
<tr>
<th>Substance Use Disorders</th>
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</thead>
<tbody>
<tr>
<td>• Benefit period begins with the first day of covered treatment and ends 365 days later.</td>
</tr>
<tr>
<td>• Benefits provide up to 60 individual or group outpatient therapy sessions and up to 15 family therapy sessions per benefit period when provided in a TRICARE-authorized facility.</td>
</tr>
<tr>
<td>• Services must be rendered by institutional providers and always require prior authorization.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Psychological testing is generally approved up to six hours per year and requires a medical necessity review and prior authorization.</td>
</tr>
<tr>
<td>• Medication management checks do not require medical necessity review or authorization for up to two visits per month and do not count as a therapy session.</td>
</tr>
</tbody>
</table>
**Behavioral Health Disorder**
- Benefits provide up to 30 days per fiscal year or per admission for acute inpatient care for beneficiaries age 19 and older.
- Benefits provide up to 45 days per fiscal year or per admission for acute inpatient care for beneficiaries age 18 and younger.
- Benefits provide up to 150 days per fiscal year or per admission for care in TRICARE-approved RTCs for beneficiaries under age 21 (dependent upon facility age restrictions).

**Substance Use Disorders: Acute Inpatient Care/Detoxification**
- Covered for complications of alcohol and drug abuse or dependency and detoxification only when the patient’s condition is such that the personnel and facilities of a hospital are required.
- Covered for up to seven days per episode in TRICARE-authored facility.
- Days count toward the 30- or 45-day behavioral health care inpatient limits.

**Substance Use Disorders: Rehabilitation**
- Benefit period starts the first day of covered treatment and ends 365 days later.
- Benefits provide up to 21 days per benefit period (combined partial and/or inpatient).
- Up to seven days of detoxification are allowed per episode in addition to the 21 rehabilitative days.
- Days count toward the 30- or 45-day behavioral health care inpatient limits.
- Care must be provided in a TRICARE-authorized facility.
- Benefits provide up to one treatment episode in a one-year period and up to three treatment episodes during the beneficiary’s lifetime.

**All Behavioral Health Care Inpatient Services**
- All nonemergency admissions require prior authorization.
- Non-TRICARE Prime beneficiaries (e.g., TRICARE Standard, TRICARE Extra, TRS) living in designated catchment areas must obtain a nonavailability statement (NAS) before receiving nonemergency acute inpatient services.

**Behavioral Health Care Partial Hospitalization Programs: Coverage Details**

**All Partial Hospitalization Services**
- All services require medical necessity review and prior authorization.
- A minimum of three hours of therapeutic services are allowed up to five days per week, and may include day, evening, night, and weekend programs.

**Behavioral Health Disorder**
- Benefits provide up to 60 treatment days per beneficiary per fiscal year.
- The 60 treatment days are not offset by or counted toward the 30- or 45-day inpatient limit.
- Care must be provided in a TRICARE-authorized behavioral health PHP.

**Substance Use Disorder**
- Benefit period starts the first day of covered treatment and ends 365 days later.
- Benefits provide up to 21 treatment days (full day or partial day) per benefit period (combined partial and/or residential).
- Days count toward the 60-day psychiatric partial hospitalization limit.
- Care must be provided in a TRICARE-authorized substance use disorder treatment facility.
Advance Directives

It is best to ask your patient early on during care if he or she has a living will or other form of advance directive. Not only does this information get included in the patient’s chart, but by raising the issue, the patient has an opportunity to clarify his or her wishes with family members and care providers. However, advance directives take effect only in situations in which a patient is unable to participate directly in medical decision making. Appeals to living wills and surrogate decision makers are ethically and legally inappropriate when individuals remain competent to guide their own care. The assessment of decisional incapacity is often difficult and may involve a psychiatric evaluation and, at times, a legal determination.

Some directives are written to apply only in particular clinical situations, such as when the patient has a “terminal” condition or an “incurable” illness. These ambiguous terms mean that directives must be interpreted by caregivers. More recent forms of instructive directives have attempted to overcome this ambiguity by addressing specific interventions (e.g., blood transfusions, CPR) that are to be prohibited in all clinical contexts.

What if a patient changes his or her mind?

Informed decisions by competent patients always supersede any written directive.

What if the family disagrees with a patient’s living will?

If there is a disagreement about either the interpretation or the authority of a patient’s living will, the medical team should meet with the family to clarify what is at issue. The team should explore the family’s rationale for disagreeing with the living will. Do they have a different idea of what should be done? Do they have a different impression of what would be in the patient’s best interest given his or her values and commitments? Or does the family disagree with the physician’s interpretation of the living will?

These are complex and sensitive situations, and a careful dialogue can usually identify many other fears and concerns. However, if the family merely does not like what the patient has requested, they do not have much ethical power to sway the team. If the disagreement is based on new knowledge, substituted judgment, or recognition that the medical team has misinterpreted the living will, the family has much more say in the situation. If no agreement is reached, the hospital’s ethics committee should be consulted.

How should I interpret a patient’s advance directive?

Living wills generally are written in ambiguous terms and demand interpretation by providers. Terms like “extraordinary means” and “unnaturally prolonging my life” need to be placed in context of the patient’s values in order to be meaningfully understood. More recent forms of instructive directives have attempted to overcome this ambiguity by addressing specific interventions (e.g., blood transfusions, CPR) to be withheld. The Durable Power of Attorney for Health Care or a close family member often can help the care team reach an understanding about what the patient would have wanted. Of course, physician-patient dialogue is the best guide for developing a personalized advance directive.

What are the limitations of living wills?

Living wills cannot cover all conceivable end-of-life decisions. There is too much variability in clinical decision making to make an all-encompassing living will possible. Persons who have written or are considering writing advance directives should be made aware of the fact that these documents are insufficient to ensure that all decisions regarding care at the end of life will be made in accordance with their written wishes. They should be strongly encouraged to communicate preferences and values to both their medical providers and family or surrogate decision makers.
Another limitation of advance directives is potential changes in the patient’s preferences over time or circumstance. A living will may become inconsistent with the patient’s revised views about quality of life or other outcomes. This is yet another reason to recommend that patients communicate with their physicians and family members about their end-of-life wishes.

**Referral Process**

A referral is the process of sending a patient to another professional provider (physician or psychologist) for consultation or health care services that the referring source believes are necessary, but is not prepared or qualified to provide. An example of a referral is when a primary care manager (PCM) sends a patient to see a cardiologist to evaluate chest pain. Referrals are professional services that are not considered primary care, that is, physician services that are not from family physicians, general internists, and/or general pediatricians. The referral requirements are based on where the beneficiary resides (within a military treatment facility [MTF] TRICARE Prime Service Area [PSA] versus a non-MTF TRICARE PSA) and the beneficiary category (TRICARE Prime versus TRICARE Standard). The initial consult is valid for 90 days. Follow-up visits are valid up to 180 days for the number of visits specified.

**Note:** Active duty family members (ADFMs) enrolled in an overseas TRICARE Prime option, including TRICARE Global Remote Overseas (TGRO), do not require a referral and authorization for care when traveling in the United States, and point of service (POS) fees do not apply to them.

Coordinate specialty care referrals with Health Net Federal Services, LLC (Health Net) based on the following guidelines.

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

All other beneficiaries enrolled in TRICARE Prime and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) must coordinate their referrals through their PCM and network specialty care providers, except for emergency care, preventive care services from network providers, the eight initial outpatient behavioral health visits to network providers, or when they choose to use the POS option. See “Health Net Referral Requirements (by Beneficiary Category)” below for additional details on Health Net referral coordination.

**Active Duty Service Members**

Active duty service members (ADSMs), including those enrolled in TRICARE Prime Remote (TPR), require a referral from Health Net for civilian (network or non-network) provider specialty care.

**TRICARE Standard Beneficiaries**

TRICARE Standard beneficiaries do not require a referral from Health Net. They may self-refer to TRICARE-authorized providers. However, some services require prior authorization by Health Net. See “Prior Authorization Process” later in this section.

**TRICARE For Life Beneficiaries**

Beneficiaries using TRICARE For Life do not require a referral from Health Net.

**TRICARE Beneficiaries with Other Health Insurance**

Beneficiaries (excluding ADSMs) with other health insurance (OHI), which is the primary payer before TRICARE, may self-refer to TRICARE-authorized providers. However, some services require prior authorization from Health Net. See “Prior Authorization Process” later in this section.

**Health Net Referral Requirements (by Beneficiary Category)**

Certain types of TRICARE beneficiaries may require a referral from Health Net for specialty care. Civilian providers can access the Referral Decision Tool located under the “Authorizations” tab on the Provider Portal of the Health Net Web site at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com) to determine if a Health Net referral is required.
To use the tool:

- Select the beneficiary’s TRICARE program/plan option and, if a TRICARE Prime beneficiary, the PCM type.
- Enter the beneficiary’s home ZIP code.
- Select “Submit.”

The tool will process the entry and identify if Health Net requires a referral. If a Health Net referral is required, Health Net will also confirm if the MTF offers the specialty service being requested and determine its ability to accept the patient before care is referred to the civilian network.

**Requesting Referrals from Health Net**

Civilian providers can request referrals from Health Net online, by fax, or by telephone. Civilian providers who have Internet access are encouraged to use the Online Authorization and Referral Submission Tool under the “Authorizations” tab on the Provider Portal at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com) for electronic submission of referral requests. For your convenience, the Online Authorization and Referral Submission Tool also has an “auto population” feature that allows you to create a Requesting Provider Personal Directory that retains the requesting provider’s tax identification number, name, address, and other demographic information. It also allows you to create a Servicing Provider Personal Directory that retains servicing provider information for later use. Providers may also track the status of their referral via the Referral and Authorization Status Tool, which is also located under the “Authorizations” tab on the Provider Portal of the Health Net Web site.

If faxing a request, civilian providers will need to complete the TRICARE Service Request/Notification Form. The form can be accessed at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com), where a sample completed form and detailed instructions are also available. To prevent delays in processing your request, remember these important guidelines when completing and faxing the form:

- If filling out the form by hand, be sure to write legibly so that all letters and numbers are clear.
- Be sure to complete every section of the form, including clinical history/previous treatment and supporting test results, in order for Health Net to process the request in a timely fashion.
- Once the form is complete, fax it to 1-888-299-4181. Do not include a fax cover sheet.
- Fax each patient referral request separately.

To prioritize referral requests, civilian providers should follow the guidelines listed in Figure 7.1 on the following page. Health Net will contact the provider’s office if further information or clarification is needed. If your office is not equipped with Internet access or a fax machine, you may request a referral from Health Net by calling 1-877-TRICARE (1-877-874-2273). If care cannot be provided at an MTF, Health Net will arrange for services within the civilian network.

If a civilian specialty provider wants to refer a TRICARE patient to a sub-specialist, the specialty provider must contact the patient’s PCM only if the sub-specialty care is outside of the scope of the initial approved referral or prior authorization. With an active referral in place, an orthopedic surgeon may refer to a hand surgeon, spine surgeon, physical therapy, or occupational therapy, without going back to the PCM. If, however, that specialty care is available at an MTF, Health Net will guide the referral to the MTF. The PCM will contact Health Net to request additional services when necessary according to the referral and prior authorization requirements. Refer to “Referral Process” and “Prior Authorization Process” in this section. Specialists can make requests to Health Net directly for additional visits or services when there is an “active” or already-approved referral or prior authorization in place.

**Note:** If the PCM refers a patient for consultation only, Health Net will issue a referral for an initial consultation and one follow-up visit. Specialists cannot request additional visits or services for those types of “consult-only” authorizations. The beneficiary will need to coordinate with his or her PCM. See “Additional Referral/Prior Authorization Requests from Specialists” later in this section if additional services are needed beyond the scope of the initial referral.
Prioritizing Referral Requests

MTF providers should coordinate referral requests with Health Net based on the specific guidelines established between Health Net and their MTF.

The following referral process should be followed for both civilian and MTF providers:

- **Request Services**—The PCM must include a written explanation of the services that are being requested to be performed by the specialist.

- **Prepare Beneficiary for Referral**—The PCM must provide the beneficiary with all the necessary medical records, laboratory results, or X-rays, etc., for the beneficiary’s appointment with the specialist.

Once Health Net approves the referral, the beneficiary and the PCM will receive a referral confirmation letter that lists the specialty provider’s name, specialty services, and dates and/or visits that have been approved. The beneficiary should use this information to schedule the first appointment with the specialist. If the beneficiary desires to see a network provider other than the one indicated on the referral letter, they may do so. There is no need to notify Health Net of this change. However, if the beneficiary does notify Health Net of their desire to see a different provider, Health Net will issue a new referral letter (to the provider) with the new provider’s name on the referral letter.

### Coordinating a Second Opinion

Beneficiaries may contact you to schedule an appointment for a second opinion. Beneficiaries have a right to request a consultation with another provider for a second opinion when the initial provider is uncertain about a contemplated course of action. Second opinions require approval by Health Net for TRICARE Prime beneficiaries in TRICARE PSAs. When approved, these requests cover the consultation visit and one follow-up visit. Additional services will not be approved by Health Net without an approval from the beneficiary’s PCM.

### Referral Requirement Exceptions

- Behavioral health services provided by licensed or certified mental health counselors or pastoral counselors require documentation of a referral and supervision by a physician (M.D. or D.O.).

- TRICARE Prime beneficiaries may self-refer for emergency services, clinical preventive services from a network provider, and the initial eight outpatient behavioral health care visits from a network provider (except when the service is scheduled or anticipated within 24 hours:

  - **Do not** send a fax or submit the request online.
  - **Call Health Net for a telephone referral request at 1-877-TRICARE (1-877-874-2273).**
  - Choose the option for “authorizations and referrals.”
  - Clearly state that the referral is urgent when speaking with the Health Net representative.

When the service is scheduled or anticipated within 72 hours:

- **Fax** a completed TRICARE Service Request/Notification Form without a cover sheet to 1-888-299-4181.
  - Write the word “URGENT” in large capital letters at the top to identify the need for expedited processing.

When requesting a routine referral:

- Make the request at least seven days prior to the anticipated date of the service in one of the following ways:
  - **Online**—Submit the request using the Online Authorization and Referral Submission Tool at www.healthnetfederalservices.com.
  - **By fax**—Fax a completed TRICARE Service Request/Notification Form without a cover sheet to 1-888-299-4181.

1. Routine referrals relate to care needed within the four-week TRICARE specialty care access standards. Nearly all referral requests are “routine” requests, unless the patient needs care in less than 72 hours.
ADSMs). ADSMs always require a referral for civilian specialty care, including behavioral health care services.

- If TRICARE Prime beneficiaries self-refer to civilian providers without a referral from their PCM (for other than emergency services, clinical preventive services, and the initial eight outpatient behavioral health care visits), they are using their POS option and are subject to a deductible and higher cost-shares. **Note:** The POS option does not apply to ADSMs.

Under the TPR option, the service point of contact (SPOC), PCM, and Health Net will coordinate the arrangements for all required military examinations for ADSMs. Civilian PCMs must contact Health Net to initiate the referral process.

The SPOC will provide the protocol, procedures, and required documentation through Health Net to the provider performing the examination. The SPOC also will review requests for specialty and inpatient care to determine the impact on fitness for duty and whether the service member will receive related fitness-for-duty care at an MTF or with a civilian provider.

**Referral Review Guidelines**

The primary goal of the PCM is the achievement of optimal health status for beneficiaries through straightforward, or low complexity decision making, appropriate use of diagnostic technology, and performance of therapeutic procedures. The PCM’s responsibilities for TRICARE Prime patients are personal, comprehensive, and continuous. PCMs are responsible for their patients’ health care, with the exception of emergency circumstances or a medical condition that requires consultation or treatment by a specialist. When care by one or more specialists is required, the PCM is responsible for coordination of all services rendered by specialists involved with his or her patient.

The following primary care services are expected to be performed by the PCM and may be referred only when consultation and complexity of decision making is required by a specialist:

- Most clinical preventive services (*The beneficiary can receive preventive services from other network providers.*)
- Management of minor illness or injury
- Minor counseling
- Management of stable chronic conditions
- Decision making that is straightforward or of low complexity

**Prior Authorization Process**

A prior authorization is a process of reviewing certain medical, surgical, and behavioral health care services to ensure medical necessity and appropriateness of care prior to services being rendered. For example, a specific diagnostic service, hospitalization, or an invasive or therapeutic procedure may require a prior authorization.

Prior authorization must be submitted to Health Net prior to services being rendered. Prior authorizations for medical or surgical services will have a begin date and an end date. Prior authorizations for behavioral health care services are valid for the number of visits specified and will have a begin date and an end date.

Depending on the type of beneficiary requesting the service, TRICARE requires prior authorization for nonemergency inpatient and some outpatient services. Civilian network and non-network providers must obtain prior authorization for all services that require prior authorization as defined by Health Net and TRICARE. Some services that do not require authorization may be excluded or have limitations in coverage. Refer to the *Medical Coverage* section of this handbook for a summary of services with exclusions and/or limitations. In most cases, the provider will receive prior-authorization notification within two to five business days, unless additional information is required. **Note:** Network provider claims submitted for services rendered without obtaining a required prior authorization are subject to a 10 percent penalty of the negotiated rate.

**Prior Authorization Requirements**

Prior authorization requirements are subject to change as a result of TRICARE program modifications and/or during annual prior authorization requirement reviews in accordance with Health Net’s TRICARE Department of Defense (DoD) contract. Prior authorization
requirements are reviewed annually to evaluate medical and behavioral health care trends and to better control health care costs for the government.

**Services Requiring Prior Authorization**

The services listed in Figure 7.2 require prior authorization. This list became effective on February 1, 2006.

Because these prior authorization requirements are subject to change, Health Net created the Prior Authorization Determination Tool, available under the “Authorizations” tab on the Provider Portal at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com), for providers to use to determine current prior authorization requirements. Providers can enter a valid Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System code into the tool and receive a response on whether the service requires prior authorization from Health Net. Providers can also use the tool to retrieve accurate code designations and descriptions. Providers without Internet access can call Health Net at 1-877-TRICARE (1-877-874-2273) for assistance with prior authorization requirements.

### TRICARE North Region Prior Authorization Requirements

**For ADSMs Enrolled in TRICARE Prime or TPR**

- Inpatient and outpatient services from a civilian network or non-network provider

**Exception:** The following ancillary services do not require prior authorization when the care has been referred by the ADSM’s PCM or specialist to a network provider:
  - Diagnostic radiology and ultrasound services
  - Diagnostic nuclear medicine services
  - Pathology and laboratory services
  - Cardiovascular studies

ADSM care is typically provided at an MTF, which authorizes care. However, TPR ADSMs are often not located near an MTF and may need care from a civilian (network or non-network) provider. All ADSMs must also notify Health Net of emergency room services within 24 hours or the next business day of care being received.

### For TRICARE Prime (other than ADSMs) and TPRADFM Enrollees

- Adjunctive dental care, including:
  - Craniofacial and maxillofacial procedures
  - Dental procedures not related to the basic dental benefit

- Durable medical equipment (DME):
  - DME—purchase greater than or equal to $2,000
  - DME—rental for all DME categorized by Centers for Medicare and Medicaid (CMS) as capped rentals

**Payment Class:** Capped rental items—These are DME items that do not fall under any of the other DME payment categories. They are generally expensive items that have historically been routinely rented, e.g., apnea monitor, ambulatory infusion pump, lightweight wheelchair.

**Note:** A certificate of medical necessity is required for DME with a purchase price between $150 and $2,000 and any rental of DME not categorized as a capped rental.

- Extended Care Health Option (ECHO) services
- Home health services, including home infusion
- Hospice
- Inpatient admissions:
  - All elective acute inpatient admissions
  - Emergency medical/surgical and behavioral health inpatient admissions require notification to Health Net within 24 hours of admission or the next business day.
Civilian Prior Authorization Requests

Civilian providers can request prior authorizations from Health Net online, by fax, or by telephone. Civilian providers who have Internet access are encouraged to use the Online Authorization and Referral Submission Tool under the “Authorizations” tab on the Provider Portal of the Health Net Web site. If faxing a request, civilian providers will need to complete the TRICARE Service Request/Notification Form. Access the form by visiting www.healthnetfederalservices.com. A sample completed form and detailed instructions also
are available on the site. To prevent delays in processing your request, remember these important guidelines when completing and faxing the form:

- If filling out the form by hand, be sure to write legibly so that all letters and numbers are clear.
- Reference the beneficiary’s name, sponsor identification number (sponsor’s Social Security number [SSN]), and a description of the service(s) being requested (including the diagnosis and CPT codes).
- Be sure to complete every section of the form, including clinical history/previous treatment and supporting test results, in order for Health Net to process the request in a timely fashion.
- Once the form is complete, fax it to 1-888-299-4181. Do not include a fax cover sheet.
- Fax each patient request separately.

To prioritize prior authorization requests, civilian providers should follow the guidelines listed in Figure 7.3.

Health Net will contact the provider’s office if further information or clarification is needed. If your office is not equipped with Internet access or a fax machine, you may request a prior authorization from Health Net by calling 1-877-TRICARE (1-877-874-2273).

If the services meet the required criteria, Health Net will assign a prior authorization number and notify the provider of the number. Providers will receive a determination letter responding to the prior authorization request. The letter will include authorization information or a request for additional information to determine medical necessity.

- For outpatient services, the letter will include an authorization number for the approved service(s) or will provide guidance on the process for appealing the denied authorization.
- For inpatient services, the letter will include a tracking number that will be issued for the prior authorization request upon notification of the admission.
- After medical review and discharge information is obtained, an authorization number will be issued to the facility. Civilian providers should submit the authorization number with their TRICARE claim to expedite claims payment. See the Claims Processing and Billing Information section for tips on submitting claims with prior authorization numbers.

### Prioritizing Prior Authorization Requests

#### Figure 7.3

<table>
<thead>
<tr>
<th>When the service is scheduled or anticipated within 24 hours:</th>
<th><strong>Do not</strong> send a fax or submit the request online.</th>
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<tbody>
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<td>• <strong>Call</strong> Health Net for a telephone request at 1-877-TRICARE (1-877-874-2273).</td>
</tr>
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<td></td>
<td>• <strong>Choose</strong> the option for “authorizations and referrals.”</td>
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<td>• Clearly state that the prior authorization is <strong>urgent</strong> when speaking with the Health Net representative.</td>
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<tr>
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<td>• Write the word “URGENT” in large capital letters at the top to identify the need for expedited processing.</td>
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<th>When requesting a routine prior authorization¹:</th>
<th><strong>Make the request at least seven days prior</strong> to the anticipated date of the service in one of the following ways:</th>
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<tr>
<td></td>
<td>• <strong>Online</strong>—Submit the request using the Online Authorization and Referral Submission Tool at <a href="http://www.healthnetfederalservices.com">www.healthnetfederalservices.com</a>.</td>
</tr>
<tr>
<td></td>
<td>• <strong>By fax</strong>—Fax a completed TRICARE Service Request/Notification Form without a cover sheet to 1-888-299-4181.</td>
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¹. Routine prior authorizations relate to care needed within the four-week TRICARE specialty care access standards. Nearly all requests are “routine” requests, unless the patient needs care in less than 72 hours.
Schedule the Service(s)—Assist the beneficiary with scheduling the requested services.

If a civilian specialty provider wants to refer a TRICARE patient to a sub-specialist, the specialty provider must contact the patient’s PCM only if the sub-specialty care is outside of the scope of the initial approved referral or prior authorization. Specialists can make requests to Health Net directly for additional visits or services when there is an “active” or already-approved referral in place.

Emergency Prior Authorizations

Emergency admissions do not require prior authorization. However, facilities should notify Health Net of an emergency room inpatient admission by faxing the patient’s hospital admission record face sheet, within 24 hours or the next business day, to 1-888-299-4181.

Referrals and Authorizations and Other Health Insurance

TRICARE beneficiaries who have OHI are not required to obtain TRICARE referrals or prior authorizations for covered services, except in the following cases:

• Adjunctive dental care
• Behavioral health care services
• All nonemergency inpatient admissions for substance use disorder or behavioral health
• PHPs and RTC programs
• Psychotherapy after the initial eight outpatient visits
• Psychoanalysis
• ECHO services
• Home health services
• Hospice services
• Solid organ and stem cell transplants

Additionally, if the OHI benefits are exhausted, TRICARE becomes the primary payer and additional prior authorization requirements may apply.

Military Treatment Facility Provider Prior Authorization Requests

MTF providers should follow MTF procedures for authorizations within the MTF. For care being coordinated outside of the MTF, providers should coordinate referral requests with Health Net based on the specific guidelines established between Health Net and their MTF.

ECHO Prior Authorization Requests

Providers rendering care for beneficiaries under ECHO should follow these steps to request prior authorizations in the North Region:

• Online through the Health Net Web site at www.healthnetfederalservices.com.
• Complete a TRICARE Service Request/Notification Form and fax it to 1-888-299-4181. You will find a sample of this form by visiting Health Net’s Web site or by calling 1-877-TRICARE (1-877-874-2273).
• Complete all information requested on the online and fax forms, including clinical history/previous treatment and supporting test results.

Additional Referral/Prior Authorization Requests from Specialists

Specialists can make requests directly to Health Net for additional visits or services beyond the initial authorization. For a specialist to request additional visits or services there must be an “active” or already-approved referral or prior authorization in place. Note: If the PCM refers a patient for consultation only, Health Net will issue a referral for an initial consultation and one follow-up visit. Specialists cannot request additional visits or services for consultation-only authorizations. The beneficiary will need to coordinate any additional requests for services with his or her PCM. To request additional visits or services, specialists must:

• Contact Health Net via fax at 1-888-299-4181 or use the Online Authorization and Referral Submission Tool.
• Provide Health Net with the original referral or authorization number assigned to the specific patient’s initial referral or authorization.
• Identify on the TRICARE Service Request/Notification Form that this is a request for additional visits or services associated with the initial referral or authorization.

**Appeals of Prior Authorizations**

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

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

According to TRICARE guidelines, an appropriate appealing party is:

- The TRICARE beneficiary (including minors)
- The non-network participating provider of care
- The appointed representative of an appropriate appealing party

A custodial parent of a minor beneficiary is considered the “appointed representative” of the minor beneficiary until the beneficiary reaches 18 years of age (21 years of age for Pennsylvania residents), at which time the beneficiary must submit the appeal on his or her own behalf or appoint a representative (e.g., parent) in writing.

A TRICARE network provider is not an appropriate appealing party. However, the TRICARE network provider may be appointed by an appropriate appealing party to represent them in the TRICARE appeal.

An MTF provider or other employee of the United States Government is not a proper appealing party and, due to conflict of interest, may not be appointed as representative (except a government employee or uniformed services member who represents an immediate family member).

If the appropriate appealing party appoints another party to act on his or her behalf in the appeals process, the appropriate appealing party must complete an Appointment of Representative and Authorization to Disclose Information form. The form is available in the “Forms Library” under “Popular Pages” on the Health Net Web site at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com). This form must be completed in its entirety and submitted with the appeal request.

The following guidelines apply when requesting a reconsideration:

- A letter requesting reconsideration must be submitted in writing and clearly marked “Reconsideration.”
- The written correspondence must reference the beneficiary’s name, sponsor identification number (sponsor’s SSN), a description of the service(s) being requested (including the diagnosis and CPT codes), and the issue in dispute.
- The written correspondence must be signed by the appealing party or the appointed representative.
- The request must include a copy of Health Net’s denial notification letter.
- The request must be postmarked or received by the filing deadline outlined as follows in the instructions for requesting a reconsideration.
- Additional documentation in support of the appeal may be submitted.

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

The type of appeal available depends on whether the care has already been received and the urgency of the situation. Instructions for filing the request for reconsideration are provided in the Health Net denial notification letter.
Expedited Reconsideration—An expedited reconsideration is a case involving care that has not yet been rendered because it has been denied on the basis that it is not medically necessary. The reconsideration request must be submitted within three calendar days of receipt of this denial determination.

Urgent Expedited Reconsideration—An urgent expedited reconsideration is a case where the care has been denied on the basis that it is not medically necessary and the care has not yet been provided. The “urgency” status is warranted in instances when awaiting the expedited processing time frame of three calendar days (as previously detailed) could:

- Seriously jeopardize the life or health of the patient and/or
- Subject the patient to severe pain that cannot be adequately managed throughout the care or treatment

Non-Expedited Reconsideration—A non-expedited reconsideration is any reconsideration that does not qualify as either an “Urgent Expedited Reconsideration” or an “Expedited Reconsideration.” The care has been denied on the basis that it is not medically necessary and care has not yet been rendered, or it is a denial determination based on coverage limitations contained in 32 CFR 199 and the TRICARE Policy Manual.

Depending on the nature of the reconsideration, you may submit your request:

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<tr>
<th>Online</th>
<th>Via the Health Net Web site at <a href="http://www.healthnetfederalservices.com">www.healthnetfederalservices.com</a> Select the online Request for Appeal form from either the Beneficiary or Provider Portal by clicking the “Forms Library” link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax</td>
<td>Through Health Net’s confidential fax at 1-888-881-3622</td>
</tr>
<tr>
<td>Mail</td>
<td>Health Net Federal Services, LLC TRICARE North Authorization Appeals P.O. Box 870142 Surfside Beach, SC 29587-9742</td>
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ADSM Reconsiderations

Under TPR, if an ADSM is notified by his or her PCM, TRICARE-authorized provider, a civilian provider, Health Net, or the SPOC that a request for services has been denied, the service member may have the right to a reconsideration. ADSMs in the Army, Navy, Air Force, Marine Corps, or Coast Guard may direct questions and initiate reconsiderations by calling the Military Medical Support Office at 1-888-647-6676. If the provider submits the reconsideration on behalf of the service member, the provider must obtain an Appointment of Representative and Authorization to Disclose Information form signed by the service member.

Providing Care to Beneficiaries from Other Regions

Emergency and Urgent Care

Under all TRICARE programs, no referrals or authorizations are required for TRICARE beneficiaries receiving emergency care in or out of their TRICARE region. However, TRICARE Prime beneficiaries are instructed to contact their PCM or regional contractor (e.g., Health Net; Humana Military Healthcare Services, Inc.; TriWest Healthcare Alliance Corp.) within 24 hours of an inpatient admission or the next business day to coordinate ongoing care.

TRICARE Prime beneficiaries must receive a referral from their PCM or regional contractor for urgent care. If they do not receive a referral, the claim will be paid under the POS option.

If you provide emergency or urgent care services to a TRICARE beneficiary from a different region, the beneficiary will be responsible for payment of the applicable cost-share, and you will submit reports and claims information to the region where the TRICARE beneficiary resides, not the region in which he or she received care. See the Claims Processing and Billing Information section for more information.

Routine Care

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

- TRICARE Standard beneficiaries will pay applicable cost-shares, and providers will submit claims to the region where the beneficiary resides, not the region in which he or she received care.
- TRICARE Prime beneficiaries will receive a referral from their PCM or regional contractor for out-of-region care and will pay applicable cost-shares. Providers will submit claims to the region where the beneficiary resides, not the region in which he or she received care. If a TRICARE Prime beneficiary does not receive a referral for out-of-region care, claims are paid under the POS option. (See the Claims Processing and Billing Information section for more information.)

If you have questions about processing claims for beneficiaries from other regions, contact Health Net at 1-877-TRICARE (1-877-874-2273).

**Medical Records Documentation**

Health Net may review your medical records on a random-sample basis to evaluate patterns of care and compliance with performance standards. Policies and procedures should be in place to help ensure that a beneficiary’s medical record chart is appropriately organized and that confidentiality of the beneficiary’s information is maintained. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.

- **Patient Identification**—Each page of the chart must include a unique identifier, which may include patient identification number, medical record number, and first and last names.
- **Individual Records**—Each patient must have his or her own record. If information for different family members is kept in the same folder, each patient must have his or her own separate and individual section.
- **Personal Data**—Information must include name, address, date of birth, sex, and home, work, or contact phone number, as well as emergency contact information. For children, the parent’s home or work phone number or any number where parents can be reached is sufficient. For adults, the number of a friend or relative, pager number, or any number where a contact may be reached and/or a message left is sufficient.
- **Allergies**—Each record must have an allergy notation in a prominent and consistent place. If a patient has no allergies, this must be so noted. “NKDA,” “NKA,” and “O” are all acceptable notations.
- **Chronic/Significant Problem List**—A separate list of all the patient’s chronic/significant problems must be maintained. A chronic problem is defined as one that is of long duration, slow progression, or shows little change.
- **Chronic/Continuing Medication List**—Chronic/continuing medications should be listed on a medication sheet and updated as necessary with dosage changes and the date the change was made. All medications—prescribed and over-the-counter—taken on an ongoing basis, must be noted on the medication list. The drug, dose, route, duration, and quantity of all prescribed medications must be noted. A separate medication sheet is recommended, but if a physician chooses to write out all current medications at each visit, this is acceptable. Ongoing medications that have been discontinued since the last visit should be noted on the medication sheet.
- **Immunization History**—A history of all immunizations must be documented.
- **Chart Legibility**—Charts must be legible to someone other than the writer. A record that is deemed illegible by the reviewer should be evaluated by a second person.
- **Informed Consent**—Physicians must document their instructions to the patient regarding any suggested invasive procedure, making notation of the alternatives to the proposed procedure, any risk involved in the procedures, and the patient’s understanding and agreement to the planned procedure. An invasive procedure is defined as surgical entry into tissues, cavities, or organs, or repair of major traumatic injuries associated with an operative or delivery room, emergency room, or outpatient setting, including physician offices.
• **Provider Signature/Name, Each Entry**—
An individualized legible identification of the author, including his or her title, must follow each entry into the medical record whether the entry is handwritten or dictated.

• **Signature on File**—A record of the patient’s signature (*authorizing the physician to treat the patient*) must be kept in the medical record.

• **Growth Chart**—The chart is necessary for all patients 14 years of age and under. Entries must be made starting at the initial visit and at all subsequent well-child visits.

• **Initial Relevant History**—There must be evidence that the patient has been questioned on the initial visit regarding serious accidents, past surgeries, and illnesses. This may be an initial self-assessment or a History and Physical (H&P) done by the provider.

• **Smoking Status**—Smoking history for patients 12 years and older should be documented somewhere in the record if the patient has been seen by the physician for a physical assessment three or more times.

• **Alcohol or Substance Use/Abuse**—Alcohol use and/or other chemical substance use for patients 12 years and older should be documented somewhere in the record if the patient has been seen by the physician for a physical assessment three or more times.

• **Date of Each Visit**—Each and every entry must be accompanied by a date (*month, day, and year*).

• **Chief Complaint**—Each visit to the physician must have a notation specifying the reason for the visit.

• **Physical Exam Relevant to Chief Complaint**—
A notation regarding physical findings in the organ system relevant to the chief complaint should be documented. This includes both normal and abnormal findings and appropriate vital signs.

• **Diagnosis/Impression for Chief Complaint**—
The diagnosis identified during each visit should be documented.

• **Appropriate Use of Consultants**—If a patient problem occurs that is outside the physician’s scope of practice, there must be a referral to an appropriate specialist. If the physician refers a patient to a specialist unnecessarily, this also should be noted.

• **Treatment/Therapy Plan Is Documented**—
Based on the chief complaint, physical exam findings, and diagnosis, the treatment plan is clearly documented.

• **Studies Ordered Appropriately**—The studies ordered should be consistent with the treatment plan as related to the working diagnosis at the time of the visit.

• **Results Discussed with Patient**—When diagnostic studies are ordered, the physician should document that the results have been discussed with the patient and any questions have been addressed. If this information is not found, the physician or office staff should be asked what system they have for conveying lab or test results to the patient (*e.g., cards mailed out for abnormal results*).

• **Unresolved Problems for Previous Visits Addressed**—Documentation should reflect that the physician provides continuous evaluation of problems noted in previous visits.

• **M.D. Review of Studies**—There must be evidence that the physician has reviewed the results of diagnostic studies. Methods will vary, but often the physician will initial the lab report or mention it in the progress notes.

• **Results of Consultations**—When the patient is referred to another physician for consultation, there must be a copy of the results of the consult report and any associated diagnostic workup in the chart. Primary physician review of the consultation must be documented. Often the physician initials the consult report. If the PCM needed to take some action, this should be documented.

• **Date of Next Visit**—The progress notes for each visit should contain notations as to the specified time frame in which the patient should return (*in weeks, months, or as necessary*).

• **Hospital Records**—Pertinent inpatient records must be maintained in the office medical records. These records may include, but are not limited to, the following: H&P, surgical procedure reports, emergency room reports, and discharge summaries. For pediatric patients seen since birth by the PCM being audited, the Labor and Delivery records should be in the chart, including the newborn assessment.

• **Preventive Health Education**—This refers to health teaching provided to the member appropriate for age and lifestyle.
Utilization Management

Utilization Management (UM) is a process that manages the beneficiary at the point of care through prospective review, concurrent review, retrospective review, case management, and discharge planning activities. Health Net will conduct UM, case management, and clinical quality management (CQM) activities on care outside the Military Health System.

Prospective Review

Prospective review is the process of reviewing and assessing health care services before they are rendered. Prospective review procedures allow for benefit determination; evaluation of proposed treatment; determination of medical or psychological necessity; assessment of level of care required; assignments of expected length of stay for those types of care and for facilities not reimbursed on a diagnosis-related group (DRG) basis; and appropriate placement prior to the delivery of care. Failure to comply with timeliness standards for notification and prior authorization will result in payment reduction.

Health Net will query the Defense Enrollment Eligibility Reporting System (DEERS) to determine beneficiary eligibility and coordinate access to the MTFs. Health Net will monitor and identify requirements for nonavailability statements and apply InterQual® criteria for screening medical or surgical care and behavioral health care based on best business practices.

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

The prospective review program involves review of requested services for:

- Assignment of expected length of stay or treatment duration for those types of care and for non-DRG facilities
- Benefit determination
- Determination of medical or psychological necessity
- Evaluation of proposed treatment or services
- Identification of potential quality issues
- Provider and beneficiary eligibility

In addition, mandatory prior authorization requirements for selected services will be applied for elective admissions. Refer to the Prior Authorization Determination Tool under “Authorizations” at www.healthnetfederalservices.com to determine if an authorization is required.

Initial Inpatient Clinical Review

Health Net’s process for initial inpatient clinical review requires hospital providers to submit clinical information to establish the medical necessity of care for those who are admitted to their facilities and who have not received a pre-certification for services. This typically includes beneficiaries who have been admitted urgently or for emergencies, or who have not received a prior authorization for services.

Prior authorization for inpatient care is required for the beneficiary categories below:

- ADSMs—Inpatient medical/surgical and behavioral health
- TRICARE Prime—Inpatient medical/surgical and behavioral health
- TPRADFM—Inpatient medical/surgical and behavioral health
- TRICARE Standard, TRS, and OHI beneficiaries—Behavioral health care inpatient services only

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

- Emergency room documentation
- H&P
• Physician orders
• Diagnostic lab results
• Diagnostic radiology results
• Operative reports
• Physician progress notes
• Any other documentation that the reviewer considers essential to establish medical necessity

These documents are due to Health Net within 24 hours of the request. Upon review of the requested clinical information and a determination of medical necessity, a letter will be sent to your facility with a tracking number, the initial number of days assigned to the case, and the next anticipated follow-up review date.

If you have any questions regarding this process, contact the care manager assigned to your facility. The care manager’s contact information will be included with the letter from Health Net.

**Admission and Concurrent Review**

Concurrent review is the evaluation of a patient’s continued need for treatment and the appropriateness of current and proposed treatment, as well as the setting in which the treatment is being rendered or proposed. Concurrent review applies to all levels of inpatient care and partial hospitalization. If an admission or an extended stay does not meet the required criteria, a request for further review will be sent to the medical director or peer review panel.

When prospective review (prior authorization) is initiated, Health Net will secure the necessary medical information to support the medical, surgical, or behavioral health care services. Medical necessity and appropriateness of setting and treatment review is performed by the UM staff with each concurrent review utilizing InterQual criteria.

A Health Net medical management representative will contact the hospital at the time of admission to obtain initial clinical information and to discuss discharge planning needs. Subsequent contacts are made to discuss goals for length of stay and/or confirm discharge.

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

**Discharge Planning**

As the patient’s severity of illness decreases and/or begins to stabilize and the intensity of services reflect that care may be delivered in a less acute setting, the Medical Management staff will coordinate efforts with the physician directing the care (and the patient and family members) to facilitate timely and appropriate discharge. Health Net will initiate discharge planning for all admissions during the first review of the case.

**Transitional Care Program**

The transitional care program is designed for all beneficiaries to ensure a coordinated approach takes places across the continuum of care. It begins in the outpatient setting, progresses through an inpatient stay, and provides additional assistance at the time of discharge from acute care to home. Some examples of services that may be provided by the care manager may include, but are not limited to, preadmission counseling and prospective discharge education and discharge planning. This program will also fill the gap for the mild to moderately complex beneficiaries who may not qualify for other programs, such as case management or disease management, but still require more intense management of their health care needs.

**Monitoring the Clinical Quality of Care**

Concurrent review allows UM staff to interact by telephone or personal contact with attending physicians, specialists, and hospital discharge planners to facilitate smooth transitions to alternate care, when appropriate. Concurrent review is necessary for a variety of reasons, including the identification of potential quality and safety issues, early identification of outliers and case management needs, and the ability to begin the process of multidisciplinary discharge planning.
**Case Management**

Case management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes (Case Management Society of America 2002). Case management is not restricted to catastrophic illness or injury.

The case management program coordinates all aspects of medical and behavioral health treatment by directing beneficiaries at risk who require extensive, complex, and/or costly services to the most appropriate levels of care necessary for effective treatment. By providing linkages among the many services, including the MTF and TRICARE regional resources, the case manager will focus on coordinating treatment to provide quality care that is cost-effective.

Health Net offers TRICARE beneficiaries and their families focused assistance in coordinating their care. Case managers consult with the TRICARE Regional Office (TRO) as applicable, MTF points of contact, and providers regarding treatment plans. They also identify relevant resources to meet the beneficiaries’ needs in a quality and cost-effective manner.

The case management program coordinates the resources and specialized needs of the case management candidate. Health Net has guidelines for the identification of potential case management candidates. Case management is initiated upon identification of a TRICARE beneficiary with a catastrophic diagnosis, chronic long-term disease, protracted rehabilitative process, or complex health care needs that require proactive management. The case management staff contacts the PCM directing the care, in coordination with any specialty or ancillary providers, to elicit a multidisciplinary approach to facilitate the beneficiary’s care plan, reduce costs, and ensure quality health care outcomes for that beneficiary.

When Health Net identifies a beneficiary with a high-risk diagnosis; high health care costs based on frequency, intensity, and complexity of services; and/or a difficult hospital discharge, a referral is made to the case management department. A case manager will contact the appropriate MTF and TRO (as applicable) to ensure that MTF resources and TRICARE programs across the region are fully utilized and made available to the beneficiaries prior to use of civilian community resources. Case management referrals from any source are accepted and evaluated.

If you have a beneficiary who would benefit from case management, please make a referral by completing a *Case Management Referral Form* and either mailing or faxing it to the Case Management Department. A case manager will contact the beneficiary and his or her physician to discuss individual health care needs.

**Authorizations and Referrals**

PO Box 870144
Surfside Beach, SC 29587-9744

**Fax:** 1-888-299-4181

Please visit [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com) for a copy of the *Case Management Referral Form* and a guide to the types of referrals selected for case management.

Behavioral health cases evaluated for case management services are identified based on the complexity of the beneficiary’s individual needs rather than a specific diagnosis.

**Warrior Care Support Program**

Health Net introduced the Warrior Care Support (WCS) program in August 2007.

The WCS program provides health care coordination and assistance for severely injured or ill warriors once an MTF transitions the patient to the civilian health care system. The program ensures care continuity and comprehensive coordination, by a single point of contact, for total health care support.

This program is designed to encourage the warrior to focus on his or her recovery and leave the navigation of health care services to the Health Net Care Coordination Team.

With specialized and individually focused support, Health Net ensures that necessary physical and behavioral health services are accessible and
provided in a timely, coordinated fashion. Each program participant is assigned a specific health care coordinator, who personally guides them through the care continuum, ensuring seamless transitions throughout the various stages of health care and military status changes.

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

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

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

Service members are typically enrolled in the program after being identified through referrals from medical management (e.g., UM, transitional care, case management) or other Health Net associates. Other WCS program enrollments may occur through MTF or civilian provider referrals or authorizations.

If you are caring for an ADSM with significant health care challenges, please call 1-877-874-2273 to speak with a Health Net representative about the WCS program.

Retrospective Review

The TRICARE Management Activity (TMA) has designated Health Net as the multifunction peer review organization (PRO) for performance of the following retrospective review activities: medical record review (inpatient and outpatient), DRG/coding validation, focused reviews (inpatient and outpatient), and National Quality Monitoring Contractor (NQMC) liaison.

Reviews of medical records will be conducted to:

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

The following review activities will occur for all cases selected for focused retrospective review:

- Admission Review—The medical record must indicate that the inpatient hospital care was medically or psychologically necessary and provided at the appropriate level of care.
- Invasive Procedure Review—The performance of unnecessary procedures may represent a quality and/or utilization problem. The medical record must support the medical necessity of the procedure performed. Invasive procedures are defined as all surgical and any other procedures that affect DRG assignment.
- Discharge Review—Records will be reviewed using appropriate criteria (i.e., InterQual) to determine potential problems with premature discharges, as well as other potential quality problems.
- Behavioral Health Review—Behavioral health claims will be reviewed in accordance with provisions in 32 CFR 199.4 (a)(11) and (a)(12).
- Home Health Prospective Payment System Review—A monthly retrospective review of medical records and claims will be reviewed in accordance with the TRICARE Reimbursement Manual, Chapter 12, Section 8 to evaluate whether services provided were reasonable and necessary, delivered and coded correctly, and appropriately documented.
- NQMC—MAXIMUS, Inc., of Reston, Virginia, is the NQMC and will assist DoD,
Health Affairs, TMA, MTF market managers, and the TROs by providing the government with an independent, impartial evaluation of the care provided to beneficiaries within the Military Health System. The NQMC will review care provided by Health Net network providers in addition to other TRICARE contractors and subcontractors on a limited basis. The NQMC is part of TRICARE’s Quality and Utilization Review PRO program, in accordance with 32 CFR 199.15.

• An Important Message from TRICARE—TRICARE policy requires that every patient admitted to a hospital receive and sign this document that details beneficiary rights concerning coverage and payment of his or her hospital stay and post-hospital services. You may access the form on Health Net’s Web site at www.healthnetfederalservices.com. An Important Message from TRICARE also discusses the Notice of Non-Coverage typically used by hospitals to inform patients when their health insurance will no longer pay for hospital care. Providers should note that, under the rules of the TRICARE hold harmless policy, they cannot bill TRICARE beneficiaries for non-covered services unless the beneficiary agrees in advance and in writing to pay for such services. Therefore, if the beneficiary does not agree to be discharged from the hospital, the provider must have the beneficiary complete a Request for Non-Covered Services form. You may access the form at www.healthnetfederalservices.com. If the beneficiary signs the form within the stated time frames, he or she will be responsible for the charges. Otherwise, the hospital will be responsible for the beneficiary’s charges.

• DRG Validation—Selected records will be reviewed for Focused and Intensified Reviews to assure that reimbursed services are supported by documentation in the patient’s medical record. This review must determine if the diagnostic and procedural information and discharge status of the patient, as reported by the hospital, match the attending physician’s description of care and services documented in the patient’s record.

• Outlier Review—Claims that qualify for additional payment as cost-outliers will be subject to review to ensure that the additional costs were medically necessary and appropriate and met all other requirements for payment.

• Procedures and Services Not Covered by the DRG-Based Payment System—ICD-9 and CPT-4 codes will provide the basis for determining whether diagnostic and procedural information is correct and matches the information contained in the medical record.

Provision of Records
All records requested by Health Net in support of PRO functions must be submitted to Health Net within 10 calendar days and will be compensated in accordance with TRICARE Operations Manual policy. Any records not submitted or incomplete records will be subject to a technical denial for the requested dates of stay and recoupment of claims payment may be initiated.

All records requested by Health Net in support of UM, case management, and clinical quality management (CQM) activities must also be submitted within 10 calendar days, but are not subject to compensation for reimbursement.

Policy on Separation of Medical Decisions and Financial Concerns
Health Net has a strict policy that:

• UM decisions are based on medical necessity and medical appropriateness.
• Health Net does not compensate physicians or nurse reviewers for denials.
• Health Net does not offer incentives to encourage denials of coverage or service.
• Special concern and attention should be paid to the risk of underutilization.

Medical decisions regarding the nature and level of care to be provided to an enrollee, including the decision of who will render the service (e.g., PCM versus specialist, network provider versus non-network provider), must be made by qualified medical providers, unhindered by fiscal or administrative concerns. Therefore, UM decisions are made by medical staff and are based on medical necessity and medical appropriateness unhampered by fiscal constraints. Health Net does not compensate for denials nor does it offer incentives to its staff or providers to encourage denials. Health Net monitors compliance with this requirement as part of its quality improvement process.
Clinical Quality Management

Health Net is committed to providing the highest quality of health care possible to TRICARE beneficiaries by partnering with TRICARE providers who are also dedicated to this goal. In compliance with DoD requirements, Health Net has a CQM program for assessing and monitoring care and services rendered to TRICARE beneficiaries throughout the health care delivery system.

The CQM program includes the review of Potential Quality issues (PQI)/Patient Safety issues, resolution of beneficiary and provider grievances, and performance of Clinical Quality Review Studies. The CQM program is designed to identify and analyze issues and, when needed, to assure the implementation of actions for correction or improvement that are timely and appropriate. Peer review and compliance with professionally recognized standards form the basis of the PQI/Patient Safety investigation process. CQM processes include periodic reassessment to assure that improvements remain effective.

Corrective action may include but is not limited to:

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

Credentialing and Certification

Health Net and MHN, Inc. (MHN) conduct an initial credentials review on each network provider to determine if the provider meets the minimum criteria to be added to the network. All providers that wish to contract with Health Net or MHN are required to complete an extensive application form and participate in a stringent review of qualifications, education, licensure, malpractice coverage, etc. If at any time a provider no longer meets the minimum credentialing requirements during or after the credentialing review, Health Net and MHN retain the right to deny or terminate any provider who does not meet Health Net, MHN, TRICARE, or Utilization Review Accreditation Commission standards.

Additionally, a full re-credentialing review of all contracted health care providers is conducted every three years to facilitate the maintenance of current and accurate files and to ensure that the provider is still meeting all minimum requirements. As a TRICARE network provider, you are required to complete a short renewal form updating qualifications, education, licensure, malpractice coverage, adverse actions, etc.

There may be times between credentialing cycles when it is appropriate to add, change, or delete a specialty description as represented in the provider directory. Additional education or training documentation verification may be necessary to make this change if it was not verified or requested during the previous credentialing process. Please select the credentialing option at 1-877-TRICARE (1-877-874-2273) for the appropriate forms and instructions.

Health Net Conditions of Participation for Network Providers

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

General Conditions

- Be a participating Medicare provider, unless not required by the client-specific agreement
- This requirement may be waived for pediatric and obstetric-only providers in accordance with the applicable TRICARE-issued Medicare Waiver
• Valid and unrestricted professional health care license to practice in Health Net’s service area and in the area where practicing professionally
• No current or previous professional licenses that are currently revoked, suspended, or ineligible to be licensed in any jurisdiction
• Maintain professional liability insurance with limits of liability as designated by the provider agreement
• Have staff privileges in a hospital certified and participating with Medicare or accredited by The Joint Commission or by the Healthcare Facilities Accreditation Program of the American Osteopathic Association®
• This requirement may be waived when a physician’s practice does not include the need for admitting privileges in such a hospital.
• Current, valid, and unrestricted U.S. Drug Enforcement Administration registration or controlled substance certificate, if applicable to professional practice
• Completed education and training applicable to practice specialty, including applicable residency and/or fellowship
• Disclosure of all malpractice and adverse action history, including any civil or criminal court decisions
• No felony convictions related to health care services
• No current Medicare or Medicaid sanctions
• No current professional practice restrictions, including business and professional licensure and privileges with hospitals or other health care delivery organizations, including other health plans
• Completed credentialing application, appropriate attachments, and signed unmodified release and attestation

Additional Requirements for Primary Care Managers
• Provide 24-hour medical coverage
• Agree to refer TRICARE beneficiaries for specialty care, when necessary
• Have a valid tax identification number for the applicable practice site(s)

Delegated Credentials/Subcontracted Provider Functions
TRICARE network providers who have delegation agreements with Health Net must comply with agreement standards and functions as they apply to credentialing of network providers and/or other subcontracted functions. Network providers must comply with the following:

• Network provider’s credentialing plan and policies and procedures meet Health Net’s reasonable standards, guidelines, and any national accrediting standards that Health Net is required to meet.
• Network provider complies with Health Net’s Credentialing Criteria (Credentialing Standards).
• Network provider complies with applicable state and federal regulations (including compliance with applicable Medicare laws, regulations, and CMS instructions).
• Health Net retains the right to approve new professional providers and sites, and to terminate or suspend individual professional providers.
• Current and future professional providers that join the network provider must be properly credentialed and re-credentialed before they may render covered services to beneficiaries.
• Network provider will notify Health Net in writing of all new professional providers who become affiliated with and are credentialed by network provider.
• Network provider will cooperate with Health Net’s timelines and schedules related to the production of accurate provider directories.
• Network provider will maintain all records necessary for Health Net to monitor the effectiveness of network provider’s credentialing and re-credentialing process, including, but not limited to, records related to the credentialing of all current or future professional providers (Professional Provider Records).
• Annually, or upon reasonable request, a network provider will provide Health Net with its credentialing policies and procedures for review and evaluation and will permit and cooperate with Health Net’s review of network provider’s records.
• Network provider will submit credentialing and re-credentialing reports that identify those
professional providers credentialed/re-credentialed, the effective date of such actions, the most recent prior date of credentialing/re-credentialing, and the effective date of such professional provider’s participation.

• Health Net retains the ultimate authority to approve or deny any provider or site seeking to participate with Health Net.

• Health Net will have the right to audit network provider’s performance of delegated functions at any time and at least every three years. Health Net reserves the right to audit network provider as frequently as necessary to assess performance and quality as applicable.

• Health Net must be notified by network provider of any material change in its performance of delegated functions. Upon written notice, Health Net has the right to revoke and assume the functions and responsibilities delegated to network provider if Health Net determines network provider either does not or will not have the capacity, ability, or willingness to effectively perform, or is not effectively performing, the delegated function.

• If a network provider wishes to sub-delegate any delegated functions to another organization, network provider must request Health Net’s prior approval in a written request. No sub-delegation may occur prior to Health Net’s review and written approval. At Health Net’s sole discretion, it may approve or deny any requested sub-delegation. If Health Net approves any sub-delegate, then any sub-delegated function remains subject to the terms of the delegation agreement between network provider and Health Net. Health Net retains ultimate oversight of any functions of the sub-delegate.

• Health Net has the right to revoke and assume the functions and responsibilities delegated to the network provider if the network provider fails to comply or correct any delegated functions within a specified period identified by Health Net in a written notice.

**Fraud and Abuse**

Program integrity is a comprehensive approach to detecting and preventing fraud and abuse. Prevention and detection are a result of functions of the prepayment control system, the post-payment evaluation system, quality assurance activities, reports from beneficiaries, and identification by a provider’s employees or Health Net staff.

TMA has a specific office to oversee the fraud and abuse program for TRICARE. The Program Integrity Branch analyzes and reviews cases of potential fraud (intent to deceive or misrepresent to secure unlawful gain). Some examples of fraud include:

• Agreements or arrangements between the provider and the beneficiary that result in billings or claims for unnecessary costs or charges to TRICARE

• Billing for costs of non-covered or non-chargeable services, supplies, or equipment disguised as covered items

• Billing for services, supplies, or equipment not furnished or used by the beneficiary

• Duplicate billings (e.g., billing more than once for the same service, billing TRICARE and the beneficiary for the same services, submitting claims to both TRICARE and other third parties without making full disclosure of relevant facts or immediate full refunds in the case of overpayment by TRICARE)

• Misrepresentations of dates, frequency, duration, description of services rendered, or the identity of the recipient of the service or who provided the service

• Practicing with an expired, revoked, or restricted license, since an expired or revoked license in any state or territory of the United States will result in a loss of authorized provider status under TRICARE

• Reciprocal billing (i.e., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed)

• Violation of the participation agreement that results in the beneficiary being billed for amounts that exceed the TRICARE-allowable charge or cost

The Program Integrity Branch also reviews cases of potential abuse (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:

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

Providers are cautioned that unbundling, fragmenting, or code gaming to manipulate the CPT codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such a practice can be considered fraudulent and abusive. Fraudulent actions can result in criminal or civil penalties.

Fraudulent or abusive activities may result in administrative sanctions, including suspension or termination as a TRICARE-authorized provider. The TMA Office of General Counsel works in conjunction with the Program Integrity Branch in dealing with fraud and abuse. The DoD Inspector General and other agencies investigate TRICARE fraud.

To investigate any allegation of fraud, the Health Net Program Integrity Department must have the following information:

• Who committed the fraud
• When the fraud occurred (time frame)
• Where the fraud occurred
• Detailed description of the fraudulent activity

All reports of fraud and abuse undergo an exhaustive review process before any action is taken. Serious cases of fraud and abuse are reported to the government for criminal investigation and prosecution. Providers can report an incident or learn more about fraud and abuse through one of four resources:

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<tr>
<td><strong>Phone</strong></td>
<td>Health Net Fraud and Abuse Hotline</td>
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<tr>
<td></td>
<td>1-800-977-6761</td>
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<tr>
<td><strong>E-mail</strong></td>
<td><a href="mailto:program_integrity@health.net">program_integrity@health.net</a></td>
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<tr>
<td><strong>Online</strong></td>
<td><a href="http://www.healthnetfederalservices.com">www.healthnetfederalservices.com</a></td>
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<tr>
<td><strong>Mail</strong></td>
<td>Health Net Federal Services, LLC</td>
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<td>ATTN: Program Integrity</td>
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<td></td>
<td>P.O. Box 870147</td>
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**Grievances**

A grievance is a written complaint or concern on a non-appealable issue from a TRICARE beneficiary or a provider regarding a perceived failure by any member of the health care delivery team—including TRICARE military providers, Health Net, or Health Net subcontractor personnel—to provide appropriate and timely health care services, access to care, quality of care or level of care, or service to which beneficiaries or providers feel they are entitled.

The Health Net grievance process allows full opportunity for any TRICARE beneficiary, beneficiary’s representative, or network provider to report in writing any concern or complaint (grievance) regarding health care quality or service.

• The Health Net Grievance Department is responsible for the investigation and resolution of all grievances.
• Grievances are generally resolved within 60 days from receipt. Following resolution of a grievance, the grievant/aggrieved party will be notified of the review completion.

**Who May File a Grievance?**

• Any TRICARE beneficiary, sponsor, parent or guardian of an eligible dependent child, or other representative may file a grievance.
• Any TRICARE civilian or military provider may file a grievance.
**Grievance Issues**

Issues may include, but are not limited to:

- The quality of health care or service aspects, such as: accessibility, appropriateness, level and continuity of care, timeliness, effectiveness, and outcome
- The demeanor or behavior of providers and their staff
- The performance of any part of the health care delivery system, including Health Net staff
- Practices related to patient safety

**Required Information for Grievances**

When submitted by the involved beneficiary, required information for grievances includes:

- Beneficiary’s name, address, and telephone number (*include area code*)
- Sponsor’s or beneficiary’s personal identification number (*sponsor’s or beneficiary’s SSN*)
- Beneficiary’s date of birth
- Beneficiary’s signature
- A description of the issue or concern must include:
  - The date and time of the event
  - Name of the provider(s) and/or person(s) involved
  - Location of the event (*address*)
  - The nature of the concern or complaint
  - Details describing the event or issue
  - Any appropriate supporting documents

Additional information may be required when submitted by someone other than the involved beneficiary.

The involved beneficiary must sign the grievance or, if someone other than the involved beneficiary submits the grievance, the eligible representative must complete, sign, and mail or fax the *Authorization to Disclose Information* form, located on page two of the *Health Net Federal Services Grievance Form*, available at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com).

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**Submitting a Grievance Form**

Submit a *Health Net Federal Services Grievance Form* or a letter outlining the grievance information previously listed in one of the following ways:

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<tr>
<td>Fax</td>
<td>1-888-317-6155</td>
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</table>
| Mail     | Health Net Federal Services, LLC  
ATTN: Grievances  
P.O. Box 870150  
Surfside Beach, SC 29587-9750 |
| Online   | [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com) |
Claims Processing and Billing Information

North Region Claims Processor

PGBA, LLC

PGBA, LLC (PGBA) is the Health Net Federal Services, LLC (Health Net) partner for claims processing in the TRICARE North Region. Health Net’s and PGBA’s Web sites offer many online claims customer service features, including eligibility, claim status, and electronic claims submission. For more information, visit:

- www.healthnetfederalservices.com
- www.myTRICARE.com

TRICARE network providers must file their patients’ TRICARE claims with Health Net/PGBA, even when a patient has other health insurance (OHI). All network provider claims must be filed electronically. Payments made to network providers for medical services rendered will not exceed 100 percent of the TRICARE-allowable charge or the negotiated rate, whichever is less. Payments made to non-network providers who participate on claims will not exceed 100 percent of the TRICARE-allowable charge.

Non-network providers also are encouraged to take advantage of the electronic claims features available through Health Net and PGBA.

Claims Processing Standards and Guidelines

TRICARE network providers must file professional services claims electronically, and the claims must be received by Health Net/PGBA within 90 days of the date care was provided. Claims for institutional services must also be filed electronically and must be received by Health Net/PGBA within 90 days of the patient’s discharge from the inpatient facility. Where TRICARE is the secondary payer under coordination of benefits, the 90 days will commence once the primary payer has made payment or denied the claim. During a TRICARE program phase-out period (end of one TRICARE contract and start of a new one), network providers are required to use best efforts to submit all TRICARE claims within 30 days from the date services are rendered or the date of the primary payer’s explanation of benefits (EOB).

Electronic Claim Submission

Electronic claim submission allows you to submit claims directly to the Health Net/PGBA system for faster processing while reducing paperwork. We recommend the following options for electronic claims submission:

- **XPressClaim**: An online electronic claims system recommended for providers with Internet access who submit fewer than 150 TRICARE claims per month. See “XPressClaim Online Claim Processing System” later in this section for more details.
- **HealthPort Direct**: A claims vendor recommended for providers who have Internet access and are not currently submitting claims electronically through a claims clearinghouse. Visit www.healthport.com or call toll-free 1-888-CTHELP1 (1-888-284-3571) for more information on their services.
- **Claims Clearinghouses**: You can establish clearinghouse services to transmit TRICARE claims electronically to Health Net/PGBA for processing. Some providers choose this option because it allows them to submit claims to other health care payers besides TRICARE.

For assistance, call 1-877-EDI-CLAIM (1-877-334-2524).

XPressClaim Online Claims Processing System

You can reconcile claim payments and check a TRICARE patient’s claim status, eligibility, and OHI information through the Health Net Web site at www.healthnetfederalservices.com or using www.myTRICARE.com by PGBA. XPressClaim offers a secure Internet-based, real-time, online claim processing system to transmit TRICARE claims 24 hours a day, seven days a week.
XPressClaim Advantages

- XPressClaim is free. You do not have to pay an electronic media claim company or a claim “clearinghouse” to handle transactions.
- There is no additional hardware or software to buy (other than existing office personal computer and Internet connection service).
- XPressClaim accepts CMS-1500 and UB-04 claims.
- XPressClaim will adjudicate most TRICARE claims upon submission and provides a clear explanation of what TRICARE allows and what the patient owes.
- XPressClaim uses a sophisticated encryption technology to transmit claims securely. The system fully protects the confidentiality of patient records and complies with Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules and regulations.

How XPressClaim Works

When registering at www.myTRICARE.com or www.healthnetfederalservices.com for this free, online claims processing system, you will create a unique username and password instantly. Other office staff may also sign up and receive their own username and password. Each person will receive a unique Security Key Code by mail.

After registering, XPressClaim will pre-load patient information for your TRICARE patients from claims that have been processed within the past 12 months. The only time it is necessary to enter patient information is for new patients. Even then, all you need is the TRICARE sponsor’s Social Security number (SSN) and the patient’s date of birth.

XPressClaim can also handle claims submission for groups with multiple locations and multiple providers. To file claims, you will need the following:

- Dates of service
- Basic data related to the diagnosis

You can submit up to 49 lines of information on one XPressClaim.

Immediately after claim submission, you will receive an online message showing that the claim has been accepted for processing. The system also shows the TRICARE-allowable charge and the patient’s payment responsibility (if any). You can generally expect PGBA to mail payment within three to five days. If a claim is more complicated and needs to be resolved by PGBA, dedicated associates will process the claim as a priority. In most cases, these claims will be complete within 10 days or less.

Electronic Funds Transfer

To sign up for electronic funds transfer (EFT), you must register with www.myTRICARE.com and submit claims electronically. You must have signature authority, which means you are authorized to disburse funds, sign checks, and add, modify, or terminate bank account information.

When you sign in to www.myTRICARE.com, you’ll see a Provider Welcome page with an “EFT” tab at the top. Select this tab to begin the two-step sign-up process:

1. First, you’ll need to print and complete the EFT registration package and send it to PGBA as directed. Once PGBA receives your signed forms, PGBA will open your EFT account and send you a letter of notification.
2. When you receive the notification letter, you can complete your registration online at www.myTRICARE.com. In this step, you’ll select provider locations, supply bank account information, and change your payment method for each location from CHECK to EFT. Once this is completed, EFT will be available in approximately seven days.

Claims Submission Addresses

Figure 8.1 on the following page provides a listing of addresses related to claim submission for professional, institutional, ancillary, and behavioral health care providers.
Claims for Active Duty Service Members

TRICARE policy requires that active duty service member (ADSM) claims under TRICARE Prime Remote (TPR) and the Supplemental Health Care Program (SHCP) be submitted to Health Net/PGBA for processing and payment.

Note: ADSM claims will be paid at the same negotiated rate as stated in your contracted agreement. There are no copayments, cost-shares, or deductibles for ADSMs or active duty family members (ADFM) enrolled in TPR. For ADFMs, the waiver of copayments, cost-shares, and deductibles does not apply to pharmacy copayments, the TRICARE 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 the SHCP. For more information regarding balance billing, see the Important Provider Information section of this handbook.

All claims for ADSMs under TPR or SHCP should be submitted either electronically or by mail to the following address:

Health Net Federal Services, LLC
c/o PGBA, LLC/TRICARE
P.O. Box 870140
Surfside Beach, SC 29587-9740

HIPAA National Provider Identifier Compliance

Effective May 23, 2008, all covered entities must use their National Provider Identifiers (NPIs) on HIPAA standard electronic transactions in accordance with the Implementation Guide. When filing claims with NPI(s), billing NPIs are always required. When applicable, rendering provider NPIs are also required. Providers treating TRICARE beneficiaries referred by another provider should also obtain the referring provider’s NPI and include it on transactions, if available, per the Implementation Guide for each transaction. See the Important Provider Information section of this handbook for additional details on HIPAA NPI compliance.

Important Billing Tips

There are several reasons why claims are delayed or denied when they could be processed if the correct information had been submitted initially. Here are some helpful billing tips to facilitate prompt claim payments.

- Provider Identification Number—Always include the provider’s federal tax identification number and the unique three-digit suffix assigned by Health Net in Box 25 of the CMS-1500 claim form; the provider’s physical address, including ZIP code, in Box 32; and the provider’s pay-to address and ZIP code in Box 33.

- NPIs—Include all NPIs, as applicable.

- Provider Signature—Always include the provider’s signature or use a signature stamp in Box 31 of the CMS-1500 claim form. The signature stamp must be on file with Health Net/PGBA. “Signature on File” is an acceptable signature on electronic claims only.

Note: The signature of non-network providers, or an acceptable facsimile, is required on all non-network claims in accordance with...
Chapter 8, Section 4 of the TRICARE Operations Manual. If a non-network claim does not contain an acceptable signature, the claim will be returned. Because the provider’s signature block Form Locator (FL) was eliminated from the UB-04, the National Uniform Billing Committee has designated FL 80 (Remarks) as the location for the non-network provider signature if signature-on-file requirements do not apply to the claim.

Demographic Changes—You must inform Health Net if any changes occur in professional affiliation, tax identification number, office location, or telephone number. Call 1-877-TRICARE (1-877-874-2273) or visit the Health Net Web site at www.healthnetfederalservices.com to update your information. In addition, Health Net will contact network providers periodically to verify provider demographic information, panel status, and their ability to meet office appointment and access standards.

Prior Authorization—Certain services require a prior authorization from Health Net. Enter the prior authorization number in Box 23 of the CMS-1500 claim form or FL 63 of the UB-04 claim form.

Note: Network provider claims submitted for services rendered without obtaining a required prior authorization are subject to a 10 percent penalty of the negotiated rate.

Additional Prior Authorization—If you render additional services beyond what has been covered by the initial prior authorization, you must notify Health Net to ensure correct claims payment.

XPRESSClaim—XPRESSClaim is a fast, easy, and free real-time, online claims processing system available through the Health Net Web site at www.healthnetfederalservices.com and the PGBA Web site at www.myTRICARE.com. You also can reconcile claims payments, check claim status, and check OHI information through online claims tools available on these Web sites.

TRICARE Summary Payment Voucher/Remit—You will receive a copy of the TRICARE Summary of Payment Voucher/Remit with your payment from Health Net. The TRICARE Summary of Payment Voucher/Remit will reflect the services provided that pertain to the payment. You can also view online remits through the Health Net and PGBA Web sites (www.healthnetfederalservices.com and www.myTRICARE.com).

“Clean Claims”—Most “clean claims” (claims that comply with billing guidelines and requirements, have no defects or improprieties, include substantiating documentation when applicable, and do not require special processing that would prevent timely payment) will be processed within 30 days. Generally, claims aged more than 30 days will be paid interest in addition to the payable amount.

Claims Status—You can check the status of submitted claims online on Health Net’s Web site at www.healthnetfederalservices.com or the PGBA Web site at www.myTRICARE.com, or by calling 1-877-TRICARE (1-877-874-2273).

Services Provided on Behalf of Another Provider—Always clearly indicate “On Call” in a prominent place on the CMS-1500 claim form for services performed on behalf of another provider. If submitting paper claims, do not use red ink stamps.

Beneficiary Signature—Always include the TRICARE beneficiary’s signature in Boxes 12 and 13 of the CMS-1500 claim form, or you may indicate “patient not present,” if the beneficiary’s signature is on file. For laboratory and X-ray services, you may indicate “patient not present for services,” and the beneficiary’s signature is not required. Also include the TRICARE sponsor’s SSN in Box 1 of the CMS-1500 claim form or FL 60 of the UB-04 claim form.

Admitting Diagnosis—The admitting diagnosis is required on all UB-04 inpatient claims.

Itemization/Breakdown of Charges—Be sure to complete Section 24, Columns A–J (e.g., place of service, charges in Column F, date of service) of the CMS-1500 claim form to ensure proper itemization of charges.

Place of Service Codes—Use the correct Place of Service codes. (See Box 24B of the CMS-1500 claim form.)

Other Health Insurance—Always ask the patient if he or she has OHI. It is your responsibility to submit OHI benefit information in Boxes 4, 9, 11, and 29 on the CMS-1500 claim form or FL 34, 50, 54, and 58 of the UB-04 claim form, or submit an EOB statement from the OHI carrier with the TRICARE claim if submitting a paper claim.
**Note:** You may not bill the beneficiary for cost-shares or copayments when the OHI has paid more than the contractual TRICARE-allowable charge.

- **Unlisted or Unspecific CPT Codes**—When submitting a paper claim and billing with an unlisted or unspecified CPT procedure code, you must include supporting documentation describing the services rendered or the claim will be returned for this information. For electronic claims, include the codes and PGBA will request additional information from you separately when applicable.

- **Third-Party Liability (TPL)**—If billing for care that may involve TPL (diagnosis codes 800–999), instruct the beneficiary to promptly respond to any request for TPL information. Once the beneficiary returns the signed TPL form (DD Form 2527 Statement of Personal Injury—Possible Third Party Liability) to Health Net, the claim will be processed.

- **ICD-9/DSM-IV Codes**—When billing ICD-9 diagnosis codes, services should be coded to the highest level of specificity (e.g., five-digit level). DSM-IV codes are required for behavioral health conditions.

- **Services that Require Specific Units of Service**—When billing for these services, such as allergy testing and treatment, be sure to code units of service based on the description in the most current edition of the CPT publication.

- **Out-of-Region Claims**—Submit claims to the TRICARE region where the beneficiary resides and/or is enrolled. Refer to “Processing Claims for Out-of-Region Care” later in this section.

- **Beneficiaries Eligible for Medicare and TRICARE**—For beneficiaries who are eligible for Medicare and TRICARE, submit claims in the usual manner to Medicare first, and claims will automatically be transmitted from Medicare to TRICARE for secondary claims processing. Wisconsin Physicians Service (WPS) will process the TRICARE portion of the claim. Refer to “Claims for Beneficiaries Using Medicare and TRICARE” later in this section for more information.

- **Maternity Antepartum Care**—Submit claims with the appropriate level of service codes. Refer to the current edition of the CPT publication.

- **Physician Assistants/Nurse Practitioners**—When billing for a physician assistant or any other rendering provider (other than the individual provider shown in Box 33 of the claim form), you must include the provider’s name, SSN, or NPI in Column 24 of the CMS-1500 claim form.

- **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.

- **Injectables**—For injectables administered in the office, bill the appropriate Healthcare Common Procedure Coding System (HCPCS) code for the injectable being administered. When billing for a drug for which there is no defined allowable in the Medicare “J” Code Pricing File, provide the appropriate HCPCS code and the applicable National Drug Code (NDC) imprinted on the manufacturer’s drug packaging label in Column 24D of the CMS-1500 claim form. Ensure that the appropriate units are provided in Column 24G of the CMS-1500 claim form.

- **ADSM Claims**—Under TPR and the SHCP, claims should be sent to PGBA for processing and payment. There are no copayments, cost-shares, or deductibles for ADSMs.

### Hospital and Facility Billing

- Anesthesia 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.

- Emergency room charges, in conjunction with a diagnosis-related group (DRG) reimbursed hospital stay, must be billed on a separate outpatient UB-04. In addition, Revenue Code 490 (ambulatory surgery room charge) cannot be submitted on an inpatient claim and should be billed as a separate service on the UB-04. Verify the Revenue Code for accuracy—Revenue Code 490, Ambulatory Surgery; versus Revenue Code 360, Operating Room—to ensure the code is being billed correctly.

- Interim claims for DRG-based facilities (regardless of the type of contract with Health Net, e.g., per diem or case rate) are accepted when the patient has been in the hospital at least 60 days. Multiple claims for single individuals must be submitted in chronological order. Fixed-dollar parameters do not apply. Claims do not require an outlier medical review.
• Ambulatory surgery procedures falling on the TRICARE Management Activity (TMA) Addendum are reimbursed at specified rates. To ensure proper payment for those procedures not listed on the TMA Ambulatory Surgery Center (ASC) Addendum, located on the www.tricare.mil Web site, ICD-9 surgical procedure codes must have a corresponding CPT-4 code and a charge for each CPT-4 code billed. Effective May 1, 2009, hospital-based ambulatory surgical procedures are reimbursed under the TRICARE outpatient prospective payment system (OPPS). Ambulatory surgery procedures are reimbursed at the specific rates established by Medicare and TRICARE. This billing may only be submitted with Type of Bill (TOB) 13X.

• Certain surgical procedures normally reimbursed at a hospital-based surgery center can also be reimbursed at a freestanding ASC. TRICARE network providers are required to contact Health Net to obtain prior authorization for appropriate procedures performed at an ASC. Refer to the TRICARE Policy Manual, Chapter 11, Section 6.2 at http://manuals.tricare.osd.mil for more information.

Proper Treatment Room Billing

Revenue Code 076x

Determining when to use revenue code 076x (treatment or observation room) to indicate use of a treatment room can be confusing, and improper coding can lead to inappropriate billing.

Under OPPS, payment of 0510 and 0760 series revenue codes are based on the HCPCS codes submitted on the claim and reimbursed.

You may indicate revenue code 076x for the actual use of a treatment room in which a specific procedure has been performed or a treatment rendered. Revenue code 076x may be appropriate for charges for minor procedures and in the following instances:

• An outpatient surgery procedure code
• Interventional radiology services related to imaging, supervision, interpretation, and the related injection or introduction procedure

• Debridement performed in an outpatient hospital department

Revenue code 0762 is the only revenue code that should be used for observation billing.

Revenue code 076x should not be used when the claim is submitted with a TOB 083x and ASC procedure codes (only free-standing ASC facilities can utilize TOB 083x). ASC facility services are reimbursed under the ASC grouper reimbursement or OPPS, depending on the facility type. It should also not be used when the HCPCS code is blank or is an evaluation and management code.

Billing with V Codes

Health Net and PGBA remind you that it is especially important to use the proper V codes (when applicable) for claims reimbursement. A V code may designate a primary diagnosis for an outpatient claim that explains the reason for a patient’s visit to your office. V codes should be used for preventive or other screening claims; all other claims should be billed with the standard numeric ICD-9 diagnosis codes. Note: TRICARE policy defines V-code diagnoses as “conditions not attributable to a mental disorder.” Therefore, V-code diagnoses for TRICARE behavioral health care services are not covered.

Choose the Correct V Codes

Be sure to use the correct V-code diagnosis to indicate the reason for the visit. The V code must match the CPT code to indicate the procedure that you are performing as it correlates to the V-code diagnosis.

How to Bill with V Codes

V codes correspond to descriptive, generic, preventive, ancillary, or required medical services and should be billed accordingly.

Descriptive V Codes

For V codes that provide descriptive information as the reason for the patient visit, you may designate that description as the primary diagnosis. An example of a descriptive V code is a routine infant or child health visit, which is designated as V20.2.
**Generic V Codes**

For generic non-payable services, such as lab, radiology, or preop, a generic V code should not be used as a primary diagnosis. Rather, the underlying medical condition should be listed as the primary diagnosis for these ancillary services.

**Preventive V Codes**

For preventive services, a V code that describes a personal or family history of a medical condition is sufficient as a primary diagnosis without the need for additional diagnostic information. Examples are a mammography, a Pap smear, or a fecal occult blood screening.

Figure 8.2 lists clinical preventive care services and the corresponding V codes.

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**Allergy Testing and Treatment Claims**

Certain types of allergy tests are not covered under TRICARE. Prior to completing an allergy test, contact Health Net to verify if the test is an approved benefit.

When submitting claims for allergy testing and treatment, use the appropriate CPT code and indicate on the claim form the type and number of allergy tests performed. When filing claims for the administration of multiple allergy tests, group the total number of tests according to the most current CPT-4 code book definitions of relevant codes. Under Column 24G of the CMS-1500 claim form, indicate the number of replacement antigen sets (*not vials*) being billed.

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### Clinical Preventive Care Services V Codes

<table>
<thead>
<tr>
<th>Preventive Care Service</th>
<th>Proper V Codes</th>
<th>Care Intervals and Notes</th>
</tr>
</thead>
</table>
| **Colonoscopy**         | V70.0, V70.5, V70.9 | Proctosigmoidoscopy/sigmoidoscopy once every three to five years beginning at age 50.  
**Individuals at average risk for colon cancer:**  
- Colonoscopy once every 10 years beginning at age 50.  
**Individuals at increased risk for:**  
- *Hereditary non-polyposis colon rectal cancer syndrome:* Colonoscopy once every two years beginning at age 25, or five years younger than the earliest age of diagnosis for colorectal cancer in an affected relative, whichever is earlier; then annually after age 40.  
- *Familial risk of sporadic colorectal cancer:* Colonoscopy should be performed every three to five years, beginning 10 years earlier than the youngest affected relative.  
There is no copayment or cost-share required for TRICARE Prime, TRICARE Standard, and TRICARE Extra beneficiaries.  
**Note:** Computed tomographic colonography (CTC) is covered as a colorectal cancer screening *only* when an optical colonoscopy is medically contraindicated or cannot be completed due to a known colonic lesion or structural abnormality, or when other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is not covered as a colorectal cancer screening for any other indication or reason. |
| **Mammograms**          | V70.0, V70.5, V70.9 | Performed annually for women over the age of 39 (*baseline at age 35 for high risk, then annually*).  
There is no copayment or cost-share required for TRICARE Prime, TRICARE Standard, and TRICARE Extra beneficiaries.  
**Note:** The mammogram and add-on codes must be submitted on the same claim if performed on the same date of service. |
### Clinical Preventive Care Services V Codes (continued)

<table>
<thead>
<tr>
<th>Preventive Care Service</th>
<th>Proper V Codes</th>
<th>Care Intervals and Notes</th>
</tr>
</thead>
</table>
| Optometry (eye exams)    | V72.0          | **Active Duty Service Members (ADSMs)**  
  - TRICARE Prime ADSMs must receive all vision care at a military treatment facility (MTF) unless specifically referred to a network provider (*or non-network provider if a network provider is not available*).  
  - TPR ADSMs may obtain a comprehensive eye examination from a network provider as needed to maintain fitness-for-duty status without an authorization.  
  
**Active Duty Family Members (ADFMs)**  
- One routine eye exam to check for vision and diseases per calendar year, regardless of TRICARE program option.  
- Medically necessary care for injuries to the eye is covered.  
  
**Retired Service Members and Their Families** (*includes all beneficiaries other than ADSMs and ADFMs*)  
- If enrolled in TRICARE Prime, one routine eye exam to check for vision and diseases every two years is covered (*except for diabetic patients, see below*).  
- If using TRICARE Standard and TRICARE Extra, or TRICARE For Life, there is no coverage (*except for well-child benefit and diabetic patients, see below*).  
- Medically necessary care for injuries to the eye is covered.  

**Well-Child Benefit**  
For all TRICARE-eligible infants and children up to age 6:  
- Infants may receive one eye and vision screening\(^1\) during routine exam at birth and at approximately 6 months of age under the well-child benefit. Use V20.2 for eye exams under the well-child benefit.  
- Children may receive two pediatric routine eye exams\(^2\) between the ages of 3 and 6 years under the well-child benefit (*use V20.2*).  

**Diabetic Patients**  
Diabetic patients at any age are allowed one routine eye examination each calendar year.  

**Note:** For TRICARE Prime enrollees, a primary care manager (PCM) or Health Net referral is not needed, but TRICARE Prime beneficiaries must see an MTF or network optometrist or ophthalmologist. The V code can be used for the annual exam; however, if a medical condition is identified, use medical diagnosis CPT codes.  

<table>
<thead>
<tr>
<th>Preventive Care Service</th>
<th>Proper V Codes</th>
<th>Care Intervals and Notes</th>
</tr>
</thead>
</table>
| Pap Smear                | V72.3 V76.2    | Annually for women over the age of 18 (*younger if sexually active*). No primary care manager (PCM) or Health Net referral or copayment is required for TRICARE Prime beneficiaries, but they must use a network provider.  

<table>
<thead>
<tr>
<th>Preventive Care Service</th>
<th>Proper V Codes</th>
<th>Care Intervals and Notes</th>
</tr>
</thead>
</table>
| Regular Immunizations    | V20.2          | Immunizations should be administered at age-appropriate doses as suggested by the current schedule of recommended vaccines by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices at [www.cdc.gov](http://www.cdc.gov).  

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1. Infant screening includes visual acuity, ocular alignment, red reflex, and external examination.  
2. Pediatric routine eye exam includes amblyopia and strabismus examination.
A limited number of replacement antigen sets are payable pending medical review and approval. Bill with the appropriate CPT code per replacement antigen set quantity (e.g., one vial, two or more vials).

**Global Maternity Claims**

Global maternity involves the billing process for maternity-related claims for a beneficiary. Once a beneficiary has been diagnosed as pregnant, all charges related to the pregnancy are grouped under one global maternity diagnosis code. These diagnosis codes will be listed as the primary diagnosis when billing. Figure 8.3 lists examples of these codes.

### Global Maternity Diagnosis Code Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V22</td>
<td>Normal pregnancy</td>
</tr>
<tr>
<td>V22.0</td>
<td>Supervision of normal first pregnancy</td>
</tr>
<tr>
<td>V22.1</td>
<td>Supervision of other normal pregnancy</td>
</tr>
<tr>
<td>V22.2</td>
<td>Pregnant state, incidental</td>
</tr>
</tbody>
</table>

When TRICARE Prime, TPR, and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) beneficiaries are referred for specialty obstetric care, prior authorization must be obtained for both outpatient and inpatient services.

Professional and technical components of medically necessary fetal ultrasounds are covered outside the maternity global fee. The medically necessary indications include, but are not limited to, clinical circumstances that require obstetric ultrasounds to estimate gestational age, evaluate fetal growth, conduct a biophysical evaluation for fetal well-being, evaluate a suspected ectopic pregnancy, define the cause of vaginal bleeding, diagnose or evaluate multiple gestations, confirm cardiac activity, evaluate maternal pelvic masses or uterine abnormalities, evaluate suspected hydatidiform mole, and evaluate the fetus’ condition in late registrants for prenatal care.

Maternal Serum Alpha Fetoprotein and Multiple Marker Screen Test are cost-shared separately (outside the global fee) as part of the maternity care benefit to predict fetal developmental abnormalities or genetic defects. A second phenylketonuria test for infants is allowed if administered one to two weeks after discharge from the hospital as recommended by the American Academy of Pediatrics.
Claims for Mutually Exclusive Procedures

Mutually exclusive procedures are two or more procedures that are usually not performed during the same patient encounter on the same date of service. There is generally significant overlapping of services and duplication of effort with mutually exclusive procedures. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedure where the physician should be submitting only one procedure code. Example: Vaginal hysterectomy and abdominal hysterectomy are considered to be mutually exclusive.

Processing Claims for Out-of-Region Care

If you provide health care services to a TRICARE beneficiary who resides in or is enrolled in a different region, the beneficiary will pay the applicable cost-share, and you will submit reports and claims information to the region based on the TRICARE beneficiary’s enrollment address, not the region in which he or she received care. If you have a claim issue or question regarding a TRICARE patient who normally receives care in another TRICARE region, call the appropriate number listed in the following sections for assistance.

South Region
1-800-403-3950

The South Region includes Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee (excluding the Fort Campbell area), and Texas (excluding the El Paso area).

West Region
1-888-TRIWEST (1-888-874-9378)

The West Region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excluding the Rock Island Arsenal area), Kansas, Minnesota, Missouri (excluding the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner only, including El Paso), Utah, Washington, and Wyoming.

Claims for Beneficiaries Assigned to US Family Health Plan Designated Providers

Designated providers are facilities specifically contracted with the Department of Defense to provide care to beneficiaries enrolled in the US Family Health Plan (USFHP). The USFHP is offered in six geographic regions in the United States. Although it provides the TRICARE Prime benefit, the USFHP is a separately funded program different from the TRICARE program administered by Health Net. The designated provider is responsible for all medical care for a USFHP enrollee, including pharmacy services, primary care, and specialty care.

If you provide care to a USFHP enrollee outside the network or in an emergency situation, you must file claims with the appropriate designated provider at one of the addresses listed in Figure 8.4. Do not file USFHP claims with Health Net.

For more information about the USFHP, visit www.usfamilyhealthplan.org.

USFHP Designated Providers

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martin’s Point Health Care</td>
<td>P.O. Box 11410, Portland, ME 04104-7410</td>
<td>1-800-403-3950</td>
</tr>
<tr>
<td>Brighton Marine Health Center</td>
<td>P.O. Box 9195, Watertown, MA 02471-9195</td>
<td>1-888-TRIWEST (1-888-874-9378)</td>
</tr>
<tr>
<td>St. Vincent Catholic Medical Centers of New York</td>
<td>US Family Health Plan at SVCMC, P.O. Box 830745, Birmingham, AL 35283-0745</td>
<td>1-888-TRIWEST (1-888-874-9378)</td>
</tr>
<tr>
<td>Johns Hopkins Medical Services Corporation</td>
<td>6704 Curtis Court, Glen Burnie, MD 21060</td>
<td>1-888-TRIWEST (1-888-874-9378)</td>
</tr>
<tr>
<td>CHRISTUS Health</td>
<td>US Family Health Plan, ATTN: Claims, P.O. Box 924708, Houston, TX 77292-4708</td>
<td>1-888-TRIWEST (1-888-874-9378)</td>
</tr>
<tr>
<td>Pacific Medical Clinics</td>
<td>1200 12th Avenue South, Quarters 8 &amp; 9, Seattle, WA 98144-2790</td>
<td>1-888-TRIWEST (1-888-874-9378)</td>
</tr>
</tbody>
</table>
TRICARE Overseas/Foreign Claims

WPS is the claims processor for all overseas claims (except claims for ADSMs with a Puerto Rico address). If filing a claim for a beneficiary who lives in or is enrolled in one of the overseas regions, submit it to one of the addresses listed in Figure 8.5.

TRICARE Overseas Claims Contact Information

<table>
<thead>
<tr>
<th>Region</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRICARE Europe (Europe, Africa, Middle East)</td>
<td>Wisconsin Physicians Service P.O. Box 8976 Madison, WI 53708-8976 Phone: 1-608-301-2310</td>
<td></td>
</tr>
<tr>
<td>TRICARE Latin America and Canada</td>
<td>Wisconsin Physicians Service P.O. Box 7985 Madison, WI 53707-7985 Phone: 1-608-301-2311</td>
<td></td>
</tr>
<tr>
<td>TRICARE Pacific (Western Pacific, Japan, Guam)</td>
<td>Wisconsin Physicians Service P.O. Box 7985 Madison, WI 53707-7985 Phone: 1-608-301-2310/2311</td>
<td></td>
</tr>
<tr>
<td>Puerto Rico and Virgin Islands</td>
<td>Wisconsin Physicians Service P.O. Box 7985 Madison, WI 53707-7985 Phone: 1-608-301-2310/2311</td>
<td></td>
</tr>
</tbody>
</table>

Note: ADSM claims with a Puerto Rico address should be forwarded to PGBA. You may contact PGBA in any of the following ways:

<table>
<thead>
<tr>
<th>Contact Method</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>1-800-403-3950</td>
</tr>
<tr>
<td>Fax</td>
<td>1-803-713-0354</td>
</tr>
<tr>
<td>Mail</td>
<td>PGBA South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031</td>
</tr>
<tr>
<td>E-mail</td>
<td>Details at <a href="http://www.myTRICARE.com">www.myTRICARE.com</a> (access the South Region page)</td>
</tr>
<tr>
<td>Web site</td>
<td><a href="http://www.myTRICARE.com">www.myTRICARE.com</a></td>
</tr>
</tbody>
</table>

TRICARE Europe

ADFM claims or TRICARE Standard claims with an overseas address should be sent directly to WPS, the overseas claims processor. National Guard and Reserve members on orders of 30 days or less who have claims with an overseas address should also be sent to WPS. If the National Guard or Reserve member can provide a copy of his or her orders and the provider submits a copy of the orders with the claim, the claim processing will be expedited. The orders are important because they verify the member’s eligibility for TRICARE benefits.

Claims for Beneficiaries Using Medicare and TRICARE

WPS is the claims processor for all TRICARE For Life claims. If you currently submit claims to Medicare on your patient’s behalf, you will not need to submit a claim with WPS. WPS has signed agreements with each Medicare carrier allowing electronic transfer of claims directly to WPS for TRICARE beneficiaries, regardless of age. Claims processed by Medicare are submitted electronically to WPS TRICARE For Life. Beneficiaries and providers will receive an EOB from WPS TRICARE For Life once processing has been completed.

Note: Participating providers accept Medicare’s payment amount. Nonparticipating providers do not accept Medicare’s payment amount and are permitted to charge up to 115 percent of the Medicare-approved amount. Both participating and nonparticipating providers may bill Medicare.

When TRICARE is the primary payer, all TRICARE requirements apply. Refer to Chapter 13 of the TRICARE Reimbursement Manual at http://manuals.tricare.osd.mil for details.

Figure 8.6 on the following page contains important contact information for you and your patients regarding Medicare and TRICARE claims.
Claims for NATO Beneficiaries

TRICARE covers the North Atlantic Treaty Organization (NATO) foreign nations’ armed forces members who are stationed in the United States or are in the United States by invitation of the U.S. Government. The benefits are the same as for American ADSMs, including no out-of-pocket expenses for care if the care is directed by the MTF. Eligible family members of active duty members of NATO nations who are stationed in or passing through the United States in connection with their official duties are eligible for outpatient services under TRICARE Standard or TRICARE Extra. A copy of the family member’s identification card will have a Foreign Identification Number or an actual SSN and indicate on the reverse “Outpatient Services Only.”

NATO family members do not need an MTF referral prior to receiving outpatient services from civilian providers. NATO family members follow the same prior authorization requirements as TRICARE Standard and TRICARE Extra beneficiaries. Like all TRICARE Standard beneficiaries, NATO family members are responsible for TRICARE Standard deductibles and cost-shares. To collect charges for services not covered by TRICARE, you must have the NATO beneficiary agree, in advance and in writing, to accept financial responsibility for any non-covered service. You may obtain a copy of the Waiver of Non-Covered Services form at www.healthnetfederalservices.com in the Forms Library.

NATO claims for ADSMs and ADFMs should be filed electronically the same way other TRICARE claims are submitted. If claims are submitted by mail, submit to:

Health Net Federal Services, LLC
c/o PGBA, LLC/TRICARE
P.O. Box 870140
Surfside Beach, SC 29587-9740

TRICARE will not cover inpatient services for NATO beneficiaries. In order to be reimbursed for inpatient services, have the NATO beneficiary make the appropriate arrangements with the NATO nation embassy or consulate in advance.

The eligibility for NATO beneficiaries is now maintained in the Defense Enrollment Eligibility Reporting System (DEERS). Claims submission procedures are the same as for U.S. ADFMs.

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, you may contact CHAMPVA by any of the following means:

<table>
<thead>
<tr>
<th>Phone</th>
<th>1-800-733-8387</th>
</tr>
</thead>
</table>
| Mail      | VA Health Administration Center CHAMPVA
PO Box 469063
Denver CO 80246-9063 |
| Web Site  | www.va.gov/hac/forproviders |
Claims for current treatment must be filed within 365 days of the date of service. Providers may file health care claims electronically on behalf of their patients. If you wish to file a paper health care claim, CHAMPVA claim forms can be downloaded from the CHAMPVA Web site. To file a paper health care claim within the one-year claim-filing deadline, send the claim to:

VA Health Administration Center  
CHAMPVA  
P.O. Box 469064  
Denver, CO 80246-9064  
Fax: 1-303-331-7804

Written appeals may be requested if exceptional circumstances prevent you from filing a claim in a timely fashion. Send written appeals to:

VA Health Administration Center  
CHAMPVA  
ATTN: Appeals  
P.O. Box 460948  
Denver, CO 80246-0948

Note: Do not send appeals to the claims-processing address. This will delay your appeal.

If your CHAMPVA claim is misdirected to PGBA, PGBA will forward CHAMPVA claims to the CHAMPVA VA Health Administration Center in Denver, Colorado, within 72 hours of identification as a CHAMPVA claim. A letter will be sent to the claimant informing him or her of the transfer. The letter includes instructions on how to submit future CHAMPVA claims and to direct any correspondence for CHAMPVA beneficiaries to the CHAMPVA VA Health Administration Center.

Claims for the Continued Health Care Benefit Program

Humana Military Healthcare Services, Inc. (Humana Military) is the contractor for the Continued Health Care Benefit Program (CHCBP) and has partnered with PGBA for processing non-overseas CHCBP claims. CHCBP beneficiaries may request that 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 North Region claims processor for TRICARE Prime, TPR, TRADFM, TRICARE Standard, TRICARE Extra, and TRICARE Reserve Select (TRS) claims, CHCBP claims are filed to a different address within PGBA through Humana Military. Filing claims correctly ensures that your claims are paid in a timely and accurate manner. Health Net will not be able to answer any questions about CHCBP claims. File CHCBP claims electronically at www.myTRICARE.com. File all paper claims at one of the addresses listed in Figure 8.7.

CHCBP Claims Addresses

| CHCBP Adjunctive Dental Claims | P.O. Box 7037  
| Camden, SC 29020-7037 |
| CHCBP Behavioral Health Claims | P.O. Box 7034  
| Camden, SC 29020-7034 |
| All Other CHCBP Claims | P.O. Box 7031  
| Camden, SC 29020-7031 |

Claims for the Extended Care Health Option

All claims for the ECHO must have a valid written authorization.

All claims for ECHO-authorized care (including ECHO Home Health Care) that have been authorized under the ECHO program should be billed on individual line items. Unauthorized ECHO care claims will be denied.

ECHO claims will be reimbursed for the amount authorized (indicated on the written authorization provided by Health Net) or the monthly or fiscal year benefit limit, whichever is lower. Each line item on an ECHO claim needs to correspond to a line item on the service authorization, or the claim may be denied or delayed due to research and reconciliation.

The “billed amount” for procedures should reflect the service, not the applicable ECHO benefit limits. Pricing of ECHO services and items is determined in accordance with the TRICARE Reimbursement Manual.
**Note (for beneficiary-filed claims):** If a beneficiary submits a claim for the use of a privately owned vehicle, the reimbursement rate is limited to the federal government employee mileage reimbursement rate in effect on the date the transportation is provided, regardless of the number of ECHO family members being transported.

Refer to Chapter 9, Sections 4.1, 11.1, 14.1, and 18.1 of the *TRICARE Policy Manual* at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil) for additional claims information.

**Claims for TRICARE Reserve Select**

The applicable cost-shares, deductibles, and catastrophic caps for ADFMs using TRICARE Standard and TRICARE Extra should be followed for all individuals covered under TRS.

**TRICARE Network Providers**

- Claims must be filed electronically with PGBA on behalf of TRS members in the same manner as other TRICARE claims.
- Claims may be submitted through the Health Net ([www.healthnetfederalservices.com](http://www.healthnetfederalservices.com)) and PGBA ([www.myTRICARE.com](http://www.myTRICARE.com)) Web sites.
- The cost-share for all TRS members, including the National Guard and Reserve member, is 15 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 claims.
- Non-network providers are encouraged to submit their TRICARE claims electronically.
- The cost-share for all TRS-covered members is 20 percent of the TRICARE-allowable charge for covered services from non-network TRICARE-authorized providers. TRICARE will reimburse the remainder of the TRICARE-allowable charge.

- If a non-network provider does not participate on a particular claim, members will file their own claims with TRICARE for reimbursement and then pay the non-network provider.

**Note (for non-network providers):** If a non-network provider does not participate on a particular claim, the provider may not charge TRS members more than 15 percent above the TRICARE-allowable charge by federal law. This amount is the same as it is for ADFMs.

The TRICARE-allowable charge schedules can be found at [www.tricare.mil/cmac](http://www.tricare.mil/cmac).

**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 are not required to obtain referrals or prior authorizations for covered services, except in the case of the services listed in Figure 8.8.

**OHI: Services Requiring TRICARE Prior Authorization**

Figure 8.8

- Adjunctive dental care
- Behavioral health care services
- All nonemergency inpatient admissions for substance use disorder or behavioral health care services
- Partial hospitalization programs and residential treatment center programs
- Psychotherapy after the initial eight self-referred outpatient visits
- Psychoanalysis
- ECHO services
- Home health services
- Hospice services
- Solid organ and stem cell transplants
Additionally, if the OHI benefits are exhausted, TRICARE becomes the primary payer and additional prior authorization requirements may apply.

You are encouraged to ask the beneficiary about OHI so that benefits can be coordinated. Since OHI status can change at any time, it is important to obtain this information from the beneficiary on a routine basis, including family members of activated National Guard and Reserve members. You can obtain a copy of the TRICARE Other Health Insurance Questionnaire form from the Forms Library on the Health Net Web site at www.healthnetfederalservices.com. If a beneficiary’s OHI status changes, make sure to update patient billing system records to avoid delays in claim payments. If you indicate on the TRICARE Other Health Insurance Questionnaire that there is no OHI, but DEERS or Health Net’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, use the following guidelines to submit a claim.

Coordination of Benefits

• 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, EOB information from those other insurers must also be submitted with the TRICARE claim.
• In order for Health Net/PGBA to coordinate benefits, the EOB must reflect the patient’s liability (copayment and/or cost-share), the original billed amount, the allowed amount, and/or any discounts.
• When a claim has all of the necessary information (e.g., billed charges, beneficiary’s copayment, and OHI payment), Health Net/ PGBA will coordinate benefits.
• If the EOB reflects a denial by the primary carrier due to non-utilization of a network provider or failure to follow plan guidelines, TRICARE also will deny the claim.
• TRICARE will not pay more as a secondary payer than it would have in the absence of other coverage.

Completion of the Claim Form to Identify OHI

• Mark “Yes” in Box 11 (CMS-1500) or FL 34 (UB-04).
• Indicate the primary payer in Box 9 (CMS-1500) or FL 50 (UB-04).
• Indicate the amount paid by the other carrier in Box 29 (CMS-1500) or FL 54 (UB-04).
• Indicate insured’s name in Box 4 (CMS-1500) or FL 58 (UB-04).

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.

TRICARE Prime POS Option

POS cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. However, it is required that the beneficiary have prior authorization for certain covered services (listed in Figure 8.8), whether or not the beneficiary has OHI.

Calculating Payments

TRICARE does not always pay the beneficiary’s copayment or the balance remaining after the OHI payment. However, the beneficiary liability is usually eliminated. The beneficiary should not be charged the cost-share when the TRICARE EOB shows no patient responsibility. Payment calculations essentially differ by provider status as detailed below.

TRICARE Network Providers and Non-Network Providers that Accept TRICARE Assignment

TRICARE pays the lesser of:

• The billed amount minus the OHI payment
• The amount TRICARE would have paid without OHI
• The beneficiary’s liability (OHI copayment, cost-share, deductible, etc.)
Providers that Do Not Accept TRICARE Assignment

Non-participating 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, no TRICARE payment is authorized, the charge is considered paid in full, and the provider may not bill the beneficiary.

Otherwise, TRICARE pays the lesser of:

- 115 percent of the allowed amount minus the OHI payment
- The amount TRICARE would have paid without OHI
- The beneficiary’s liability (OHI copayment, cost-share, deductible, etc.)

TRICARE and Third-Party Liability Insurance

The Federal Medical Care Recovery Act allows the government to be reimbursed for costs associated with treating a TRICARE beneficiary who has been injured in an accident caused by someone else.

When a claim appears to have possible third-party involvement, certain actions must be taken that can affect total processing time. Health Net is responsible for identifying and investigating all potential third-party recovery claims.

Inpatient claims submitted with diagnosis codes between 800 and 999 (with some exclusions, as listed in Figure 8.9), regardless of the billed amount, and claims for professional services that exceed a TRICARE liability of $500, which indicate an accidental injury or illness will be pended for research. These claims will not be processed further until the beneficiary completes and submits a DD Form 2527 Statement of Personal Injury—Possible Third Party Liability. The form may be accessed from the Health Net Web site at www.healthnetfederalservices.com. There are certain diagnosis codes that are exceptions. The form is not required for the codes listed in Figure 8.9.

When a claim is received that appears to have possible third-party involvement, the following process will occur:

- The DD Form 2527 Statement of Personal Injury—Possible Third Party Liability will be mailed to the beneficiary.
- The claim is suspended for up to 35 calendar days awaiting receipt of the form from the beneficiary.
- If the DD Form 2527 is not received within 35 calendar days, the claim will be denied. (“Requested third-party liability information not received” will appear on the EOB.)
- The claim will be reprocessed when the DD Form 2527 is completed and returned by the beneficiary. Encourage the beneficiary to fill out, sign, and return the form within the 35 calendar days to avoid payment delays.
- If the illness or injury was not caused by a third party, but the diagnosis code(s) falls between 800 and 999, the beneficiary is still responsible to fill out, sign, and return the DD Form 2527. If the form is not returned, the claim will be denied. If the claim is denied due to lack of submission of the DD Form 2527 by the beneficiary, you may bill the beneficiary.

If you believe a patient needs to complete the DD Form 2527 based on the information above, it is appropriate to have copies of the form on hand for the patient to complete. Taking this precautionary step can help expedite the claim through the process and ensure timely payment for services. The DD 2527 Form is available at www.healthnetfederalservices.com.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Exceptions/Exclusions</th>
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<tbody>
<tr>
<td>910.2–910.7</td>
<td>911.2–911.7</td>
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<td>916.2–916.7</td>
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<tr>
<td>918.0</td>
<td>918.2</td>
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<tr>
<td>919.2–919.7</td>
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</table>
Completed forms can be faxed to 1-888-432-7077 or sent to Health Net’s claims processor, PGBA, at:

TRICARE Correspondence
P.O. Box 870141
Surfside Beach, SC 29587-9741

TRICARE and Workers’ Compensation

TRICARE will not share costs for services for work-related illnesses or injuries that are covered under workers’ compensation programs.

Avoiding Collection Activities

Both network and non-network providers are encouraged to explore every possible means to resolve claims issues without involving debt collection agencies. In cases where the claim has been denied, payment has been reduced, or payment is pending, your recourse is to:

- Submit an administrative review request
- Request an adjustment on an allowable charge review
- Contact Health Net/PGBA to check on the status of the claim(s)
- Health Net Web site: www.healthnetfederalservices.com
- PGBA Web site: www.myTRICARE.com

Network providers should accept as payment in full the amount payable by TRICARE for covered services. Refer to the Important Provider Information section for additional information about provider and beneficiary fiscal responsibilities.

Beneficiaries are responsible for their out-of-pocket expenses reflected on the TRICARE Summary Payment Voucher/Remit. Beneficiaries are responsible for deductible, cost-share, and/or copayment amounts.

TRICARE’s Debt Collection Assistance Officer Program

Debt Collection Assistance Officers (DCAOs) are located at each TRICARE Regional Office and MTF to assist TRICARE beneficiaries to resolve collection-related issues. Beneficiaries must bring or submit documentation associated with a collection action or adverse credit rating to the DCAO. This includes debt collection letters, EOBs, and medical/dental 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 collection agency will be notified by the DCAO that action is being taken to resolve the issue.

The DCAO cannot provide beneficiaries with legal advice or fix their credit ratings, but DCAOs can help beneficiaries through the debt collection process by providing documentation for the collection or credit-reporting agency in explaining the circumstances relating to the debt. The DCAO directory is available online at www.tricare.mil/dcao.

TRICARE Claim Disputes

TRICARE has created a claim appeal process to have your claim reviewed in the event you disagree with payment.

The following subsections detail the appropriate types of review requests, time frames for submitting the request, contact information, and the information to include with the request. By following the rules and timelines for requesting reviews, you can help to achieve prompt resolution to your request.

Claims Adjustments and Allowable Charge Reviews

An allowable charge review can be requested by a provider or beneficiary if either party disagrees with reimbursement allowed on a claim. This includes “By Report” or unlisted procedures where a provider can request a review. Requirements are listed in Figure 8.10 on page 111.
Network Provider Disputes Relating To Contractual Reimbursement Amount

Network providers who believe they have been reimbursed at an amount less than that agreed to between provider and the Managed Care Support Contractor should file a request for review to:

TRICARE North Region  
P.O. Box 870141  
Surfside, Beach, SC 29587-9741

The request for review must be submitted within 90 days of the date of the TRICARE EOB relating to the alleged underpayment and should identify, in detail, why the provider believes the reimbursement amount is incorrect. Failure to submit a request for review within these parameters and within this time frame constitutes a waiver of any such claim.

Appeals and Administrative Reviews of Claim Denials

- **Non-network provider claim denials:** Non-network, participating providers (those who accept assignment) and beneficiaries can appeal a TRICARE claim when the denial is based on a determination that the service is not a benefit under TRICARE or is not medically necessary.

- **Network provider claim denials:** Network providers who are dissatisfied with the denial of a claim can appeal under the administrative review process when the denial is based on a determination that the service is not a benefit under TRICARE or is not medically necessary.

  Note: Network providers must hold the beneficiary harmless for non-covered care. Under the “hold harmless” policy, the beneficiary has no financial liability and therefore has no appeal rights. However, if the beneficiary has waived their hold harmless rights, the beneficiary may be financially liable and further appeal rights may be offered.

Additional details regarding appeals and administrative reviews are listed in Figure 8.11 on page 112.

After your request is submitted, Health Net will notify you in writing or by telephone of the outcome.

You can also obtain more detailed information about the various levels of appeals on Health Net’s Web site at [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com).
### Requirements for Claims Adjustments and Allowable Charge Reviews

<table>
<thead>
<tr>
<th>Reviewable Issues</th>
<th>Time Frames</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>• Allowable charge complaints</td>
<td>• Requests must be postmarked or received within 90 calendar days of the date of the TRICARE EOB</td>
<td>TRICARE Correspondence: TRICARE North Region P.O. Box 870141 Surfside Beach, SC 29587-9741</td>
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<tr>
<td>• Charges denied as “Included in a paid service”</td>
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<td>• Keying errors/corrected bills</td>
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<td>• Eligibility denials/patient not in DEERS</td>
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<td>• Cost-share and deductible inquiries/disputes</td>
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<tr>
<td>• Claims denied because the provider is not a TRICARE-authorized provider</td>
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<tr>
<td>• ClaimCheck® denials (except assistant surgeons)</td>
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<td>• OHI denials/issues</td>
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<tr>
<td>• Prescription drug coverage</td>
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<tr>
<td>• Third-party liability denials/issues</td>
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<tr>
<td>• Claims denied or payments reduced due to no authorization</td>
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<td></td>
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<tr>
<td>• POS when reason for dispute is other than emergency care</td>
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<tr>
<td>• Claims denied because they were filed late</td>
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<tr>
<td>• Charges denied as a duplicate charge</td>
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<tr>
<td>• Claims denied as “Requested information was not received”</td>
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<tr>
<td>• Coding issues</td>
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<tr>
<td>• Claims denied because nonavailability statement (NAS) is not in DEERS</td>
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<tr>
<td>• Network provider disputes relating to contractual reimbursement amount</td>
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</table>

If requesting an allowable charge review, the following information is needed:

- A copy of the claim and the TRICARE EOB or TRICARE Summary Payment Voucher/Remit
- Supporting medical records and any new information that was not originally submitted with the claim
## Appealable Issues
- Claims denied because the service is not covered under TRICARE or exceeds policy limitations/coverage criteria
- Claims denied as not medically necessary
- Claims for assistant surgeon charges denied by ClaimCheck
- Claims processed as POS only when the reason for dispute is that the care was emergency

## Time Frames
- 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.

## Contact Information
TRICARE Appeals:
TRICARE North Region
P.O. Box 870148
Surfside Beach, SC 29587-9748
Fax: 1-888-458-2554

### Document Requirements:
- All appeal/administrative review requests must be in writing and must be signed.
- All appeal/administrative review requests must state the issue in dispute.
- Be certain to include a copy of the initial denial (EOB/provider remittance advice) and any additional documentation in support of the appeal.
- In addition, provide the following:
  - Sponsor’s SSN
  - Beneficiary’s/patient’s name
  - Date(s) of service
  - Provider’s address, telephone/fax numbers, and e-mail address, if available
  - Statement of the facts of the request
- Appeals must be requested by an appropriate appealing party. Persons or providers who may appeal are limited to:
  - TRICARE beneficiaries (including minors)
  - Participating, non-network, TRICARE-authorized providers of service
  - 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
    - An attorney
    - A network provider
- Administrative reviews must be requested by the network provider.

**Note:** The custodial parent of a minor beneficiary is presumed to have been appointed by the beneficiary to represent them in the appeal.
Reimbursement rates and methodologies are subject to change per the Department of Defense (DoD) guidelines.


Reimbursement Limit

Payments made to network providers for medical services rendered to TRICARE beneficiaries will not exceed 100 percent of the TRICARE-allowable charges.

If you believe a claim has been incorrectly denied, you should follow the allowable charge review process explained in “TRICARE Claim Disputes” in the Claims Processing and Billing Information section of this handbook.

CHAMPUS Maximum Allowable Charge

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) maximum allowable charge (CMAC) is the maximum amount TRICARE will reimburse for nationally established procedure coding (i.e., codes for institutional or professional services). Health Net Federal Services, LLC (Health Net) will retain and maintain CMAC files from previous years for historical purposes. Updated CMAC rates based on site of service are available on the TRICARE Web site at www.tricare.mil/cmac. Periodic CMAC changes apply to both network and non-network providers.

Site-of-Service Pricing Categories

The following four categories represent the four classes of providers used for reimbursement.

Category 1: Services of M.D.s, D.O.s, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, audiologists, and applicable outpatient hospital services provided in a facility, including:

- Ambulances
- Ambulatory surgery centers (ASCs)
- Community mental health centers
- Hospices
- Hospitals (both inpatient and outpatient where the hospital is generating a revenue bill; i.e., revenue code 510)
- Military treatment facilities (MTFs)
- Psychiatric facilities
- Residential treatment centers
- Skilled nursing facilities (SNFs)

Category 2: Services of M.D.s, D.O.s, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a non-facility, including:

- Home settings
- Provider offices
- Other non-facility settings

Category 3: Services of all other providers not found in Category 1 provided in a facility.

Category 4: Services of all other providers not found in Category 2 provided in a non-facility.

CMAC Procedure Pricing Calculator

To visit the CMAC calculator, go to www.tricare.mil/cmac and follow the online prompts. For CMAC rates from previous years, use the applicable Current Procedural Terminology (CPT®) code.

Questions about using this application can be sent to Webmaster-CMAC@tma.osd.mil.

TRICARE-Allowable Charge

The TRICARE-allowable charge is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The allowable charge is the lowest of:

(a) the actual billed charge; (b) the maximum allowable charge; or (c) the prevailing charge (or amount derived from a conversion factor) made for a given procedure, adjusted to reflect local economic conditions.
For example:

- If the TRICARE-allowable charge for a service is $90 and the billed charge is $50, the TRICARE-allowable charge becomes $50 (the lower of the two charges).
- If the billed charge is $100, TRICARE will allow $90 (the lower of the two charges).
- In the case of inpatient hospital payments, the specific hospital reimbursement method applies; e.g., diagnosis-related group (DRG) rate is the TRICARE-allowable charge regardless of the billed amount, unless otherwise stated in the provider’s contract.
- In the case of outpatient hospital claims subject to the TRICARE outpatient prospective payment system (OPPS), services will be subject to OPPS APCs, where applicable.

**State Prevailing Rates**

State prevailing rates are established for codes that have no current available CMAC pricing. Prevailing rates are those charges that fall within the range of charges most frequently used in a state for a particular procedure or service. When no maximum allowable charge is available, a prevailing charge is developed for the state in which the service or procedure is provided. Unless a specific exception has been made, prevailing profiles are developed on:

- A statewide basis (*Localities within states are not used, nor are prevailing profiles developed for any area larger than individual states.*)
- A non-specialty basis

Prevailing profiles are developed using a minimum of eight claims submitted for reimbursement to TRICARE. The prevailing rate is determined for the service by placing all actual charges billed for the service in an array by ascending order. The lowest charge (*in the array*) that is high enough to include 80 percent of the cumulative charges (*number of claims billed*) is determined to be the prevailing charge. For more details, refer to Chapter 5, Section 1 of the TRICARE Reimbursement Manual, at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil).

Per TRICARE policy, for codes with prevailing rates during the period January–October 1991, the prevailing rates were frozen at the 1990 level, consistent with Public Law (P.L.) 101–511, Section 8012. Additional new codes have been established by the American Medical Association that have no current available CMAC pricing. Those codes have not been frozen. State prevailing charges, once established, remain frozen. For more information, please refer to Chapter 5, Section 1 of the TRICARE Reimbursement Manual.

If a minimum of eight claims has not been received, the prevailing rate can be determined through the use of information about the volume of business done by various providers or suppliers within the TRICARE North Region or through available price lists and supply catalogs.

**Anesthesia Rates**

TRICARE reimbursement of anesthesia services is calculated using the number of time units, the Medicare relative value units (RVUs), and the anesthesia conversion factor.

**Anesthesia Claims and Reimbursement**

Professional anesthesia claims must be submitted on an appropriate CMS-1500 form, using the applicable CPT anesthesia codes. If applicable, the claim must also be billed with the appropriate physical status (P) modifier. The use of other optional modifiers may also be appropriate. An anesthesia claim must specify who provided the anesthesia. In cases where a portion of the anesthesia service is provided by an anesthesiologist and a nurse anesthetist performs the remainder, the claim must identify exactly which services were provided by each provider. This distinction may be made by the use of modifiers.

**Calculating Anesthesia Reimbursement**

The following formula is used to calculate the TRICARE anesthesia reimbursement:

\[(\text{Time Units} + \text{RVUs}) \times \text{Conversion Factor}\]
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 presence of the beneficiary). A base unit includes reimbursement for:

- Preoperative examination of the beneficiary
- Administration of fluids and/or blood products incident to the anesthesia care
- Interpretation of non-invasive monitoring (e.g., electrocardiogram, temperature, blood pressure, oximetry, capnography, 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

Placement of arterial, central venous, and pulmonary artery catheters and use of transesophageal echocardiography are not included in the base unit value. When multiple surgeries are performed, only the RVUs for the primary surgical procedure are considered, while the time units should include the entire surgical session. Note: This does not apply to continuous epidural analgesia.

Time Unit—Time units are determined in increments of 15 minutes. Any fraction of a unit is considered a whole unit. Anesthesia time starts when the anesthesiologist begins to prepare the beneficiary for anesthesia care in the operating room or in an equivalent area. It ends when the anesthesiologist is no longer in personal attendance and the beneficiary may be safely placed under post-anesthesia supervision. Providers must indicate the number of time units in Column 24G of the CMS-1500.

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 online 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

Ambulatory surgery facility payments (since implementation of OPPS, only non-OPPS providers will be paid under this method) 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 in the TRICARE Reimbursement Manual, Chapter 9, Addendum B at http://manuals.tricare.osd.mil. TRICARE payment rates established under this system apply only to the facility charges for ambulatory surgery.

For additional information, ambulatory surgery providers may view reimbursements and grouper assignments at www.tricare.mil/ambulatory.

Ambulatory Surgery Center Charges

Effective April 1, 2008, all hospitals or freestanding ASCs must submit claims for surgery procedures on a UB-04 claim form. Prior to this date, freestanding ASCs could submit on a CMS-1500 claim form with an SG modifier. All hospitals must submit claims on a UB-04 claim form. Hospital-based ASC providers must use Type of Bill (TOB) 13X.

Multiple Procedures

Multiple ambulatory surgeries are processed according to multiple surgery guidelines. Reimbursement is based on the sum of the following two amounts:

- 100 percent of the payment amount for the surgical procedure with the highest ASC payment grouper amount (Only one surgery in an ASC episode is paid at 100 percent.)
- 50 percent of the ASC grouper payment amount for each of the other surgical procedures performed during the same session
No reimbursement is made for incidental procedures performed during the same operative session in which other covered surgical procedures were performed. An incidental surgical procedure is one that is performed at the same time as a more complex primary surgical procedure. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure. Therefore, no reimbursement will be made for an incidental procedure unless it is required for surgical management of multiple traumas or involves a major body system different from the primary surgical service.

For free-standing ASCs and non-OPPS hospitals, in some instances of multiple ambulatory surgeries, one procedure may be on TMA’s ASC procedure list, and one may not. These claims are processed as follows:

- If the procedure on the ASC list has the highest allowable amount, the claim will process under the multiple ambulatory surgery guidelines, as noted previously.
- If the billed charge for the procedure that is not on the ASC list and is the highest allowable amount, the claim will not be reimbursed as an ASC claim. The procedure not on the ASC list (the highest allowed) will be reimbursed at 100 percent and the ASC-approved procedure will be reimbursed at 50 percent, as noted previously. Facility charges for procedures that are not on the ASC list are reimbursed at the billed charge less any contracted discounts.

**Ambulatory Surgery Rate Lookup Tool**

To find ambulatory surgery rates, go to [www.tricare.mil/ambulatory](http://www.tricare.mil/ambulatory) and follow the online prompts.

**Diagnosis-Related Group Reimbursement**

DRG reimbursement is a reimbursement system for inpatient charges from DRG facilities. This system assigns payment levels to each DRG based on the average cost of treating all TRICARE beneficiaries in a given DRG. The TRICARE DRG-based payment system is modeled on the Medicare inpatient prospective payment system (PPS). Cases are classified into the appropriate DRG by a grouper program.

The grouper used for the TRICARE DRG-based payment system is the same as the Medicare grouper with some modifications such as neonate DRGs. Refer to the *TRICARE Reimbursement Manual* at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil) for detailed information.

**DRG Calculator**

The DRG calculator is available at [www.tricare.mil/drgrates](http://www.tricare.mil/drgrates).

You 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 educational cost reimbursement. Capital items, such as property, structures, and equipment, usually cost more than $500 and can depreciate under tax laws. Direct medical education is defined as formally organized or planned programs of study in which providers engage to enhance the quality of care at an institution.

All initial requests for reimbursement under capital and direct medical education costs must be submitted to Health Net/PGBA, LLC (PGBA) on or before the last day of the 12th month following the close of the hospital’s cost-reporting period. The request shall cover the one-year period corresponding to the hospital’s Medicare cost-reporting period. This applies to hospitals (except children’s hospitals) subject to the TRICARE DRG-based system.

The submission must include a statement certifying that any changes, if applicable, were made as a result of a review, audit, or appeal of the provider’s Medicare cost report. The change(s) must be reported to Health Net/PGBA within
30 days of the date the hospital is notified of the change. In addition, an officer or administrator of the provider must certify all cost reports.

**Bonus Payments in Health Professional Shortage Areas**

Network and non-network physicians (M.D.s and D.O.s), 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 providers who are eligible for HPSA bonuses are M.D.s and D.O.s. Non-physicians (Ph.D.s, social workers, counselors, psychiatric nurse practitioners, and marriage therapists) are not eligible.

Providers can determine if they are in an HPSA by accessing the U.S. Department of Health and Human Services, Bureau of Health Professions' HPSA search tool at [http://hpsafind.hrsa.gov](http://hpsafind.hrsa.gov). There is also bonus payment information, including HPSA designations, on the Centers for Medicare and Medicaid Services (CMS) Web site at [www.cms.hhs.gov/HPSAPSAPhysicianBonuses](http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses).

**How Bonus Payments Are Calculated**

For providers who are eligible and located in an HPSA, Health Net’s claims processor, PGBA, will calculate a quarterly 10-percent bonus payment from the total paid amount for TRICARE claims that contain the modifier AQ (Health Professional Shortage Area) in Column 24D of the CMS-1500 claim form. Bonus payments will be calculated on TRICARE Prime, TRICARE Prime Remote, TRICARE Prime Remote for Active Duty Family Members, TRICARE Standard, TRICARE Extra, and TRICARE Reserve Select claims and the amount paid by the government on other health insurance (OHI) claims.

When submitting a claim for the bonus payment, providers must include the AQ CPT modifier in Column 24D of the CMS-1500 claim form. For CPT codes with multiple modifiers, place the AQ modifier last. Only the professional component will be used in the calculation of the bonus payment for services that contain both a professional and technical component. Those providers who are eligible and do not submit claims with the appropriate modifier will not receive the bonus payment from TRICARE. There are no retroactive payments, adjustments, or appeals for obtaining a bonus payment, so be sure to include the bonus payment modifier with your initial claims submission if you are eligible.

**Note:** Although Medicare no longer requires the use of modifiers, TRICARE still requires their use. If claims are submitted without the modifier, your bonus payment cannot be paid.

**Skilled Nursing Facility Pricing**

SNFs are paid using the Medicare PPS and consolidated billing. SNF PPS rates cover all routine, ancillary, and capital costs of covered SNF services. SNFs are required to perform resident assessments using the Minimum Data Set. SNF admissions for children under age 10 and critical access hospital (CAH) swing beds are exempt from SNF PPS and are reimbursed based on billed charges or contracted rates.

For more information about SNF PPS, refer to Chapter 8, Section 2 of the *TRICARE Reimbursement Manual* at [http://manuals.tricare.osd.mil](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 Health Net and renewal every 60 days. In order to receive private duty nursing or additional nursing services/shift nursing, the TRICARE beneficiary may be enrolled in an alternative TMA-approved special program and a case manager must manage his or her progress.
Tips for Filing a Request for Anticipated Payment (RAP)

- The bill type in Form Locator (FL) 4 of the UB-04 is always 322 or 332.
- The “To” date and the “From” date in FL 6 must be the same and must match the date in FL 45.
- FL 39 must contain code 61 and the Core-Based Statistical Area (CBSA) code of the beneficiary’s residence address.
- There must be only one line on the RAP, and it must contain revenue code 023 and zero dollars. On this line, FL 44 must contain the Health Insurance Prospective Payment System code. The quantity in FL 46 must be 0 or 1.
- FL 63 must contain the authorization code assigned by the Outcome Assessment Information Set. **Note:** This is not Health Net’s prior authorization number.

Tips for a Final Claim

- Network home health 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 in order 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 the lines must fall between the dates in FL 6.

Exceptions

Beneficiaries enrolled in the Custodial Care Transition Program (CCTP) are exempt from the new claim-filing rules and providers treating them may continue billing as always (fee for service). For details about beneficiaries grandfathered under the CCTP, refer to the TRICARE Policy Manual, Chapter 8, Section 15.1 at http://manuals.tricare.osd.mil.

**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Pricing**

Durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) prices are established by using the Medicare fee schedules, reasonable charges, state prevailing rates, or average wholesale pricing. Most payments of durable medical equipment (DME) are based on a fee schedule established for each DMEPOS item. The services and/or supplies are coded using CMS Healthcare Common Procedure Coding System (HCPCS) Level II codes that begin with the letters:

- **A** (medical and surgical supplies)
- **B** (enteral and parenteral therapy)
- **E** (DME)
- **K** (temporary codes)
- **L** (orthotics and prosthetic procedures)
- **V** (vision services)

Inclusion or exclusion of a fee schedule amount for an item or service does not imply TRICARE coverage or non-coverage.

In addition to the DMEPOS schedule, parenteral and enteral nutrition items and services and fees are also included. DMEPOS pricing information is available at www.noridianmedicare.com.

**Home Infusion Drug Pricing**

Home infusion drugs are reimbursed at the lesser of the billed amount or 95 percent of the average wholesale price (AWP).

Home infusion drugs are those drugs *(including chemotherapy drugs)* administered in the home by means other than oral means, e.g., the drug must be administered either intramuscularly, subcutaneously, intravenously, or infused through a piece of DME. DME verification is not required.

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 National Drug Code number of the administered drug. The TRICARE-allowable charge for these drugs will be determined and reimbursed at the lower of the billed charge or 95 percent of the AWP, as retrieved from the National Drug Data File (formerly the National Drug Blue Book). Contracted discounts may apply.
Modifiers

Industry-standard modifiers are used with procedure codes to clarify the circumstances under which medical services were performed. Modifiers allow the reporting physician to indicate that a service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers may be used by the physician 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 certified nurse midwife acting within the scope of his or her license who actively assists the operating surgeon in the performance of a covered surgical service.

TRICARE covers assistant surgeon services when the services are considered medically necessary and meet the following criteria:

• The complexity of the surgical procedure warrants an assistant surgeon rather than a surgical nurse or other operating room personnel.
• Interns, residents, or other hospital staff is unavailable at the time of the surgery.

All assistant surgeon claims are subject to medical review and need verification that the surgical procedure(s) performed required the services of an assistant surgeon and were medically necessary.

Standby assistant surgeon services are not reimbursed when the assistant surgeon does not actively participate in the surgery.

The PA or NP must actively assist the operating surgeon as an assistant surgeon and perform services that are authorized as a TRICARE benefit. When a provider bills for a procedure or service performed by a PA, TRICARE policy requires that the supervising or employing physician bill the procedure or service as a separately identified line item (e.g., "PA office visit") and use the PA’s provider number. The supervising or employing physician of a PA must be a TRICARE-authorized provider.

Supervising authorized providers that employ NPs may bill as noted for the PA, or the NP may bill on their own behalf and use their NP provider number for procedures or services they perform.

Providers should use the modifier that best describes the assistant surgeon services provided in 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.

Note: Modifiers 80 and 81 are applicable modifiers to use; however, they will most likely pend for medical review to validate the medical necessity for surgical assist and possibly have medical records requested. During this review process, the claim also will be reviewed to validate that this facility has (or does not have) residents and interns on staff (e.g., “small community hospital”).
**Surgeon’s Services for Multiple Surgeries**

Multiple surgery procedures have specific requirements for reimbursement. When multiple surgical procedures are performed, the primary surgical procedure will be paid at 100 percent of the contracted rate. The primary surgical procedure is the surgical procedure with the highest allowable 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. Therefore, no reimbursement will be made for an incidental procedure unless it is required for surgical management of multiple traumas or it involves a major body system different from the primary surgical service.

**Hospice Pricing**

The hospice program must enter into an agreement with TRICARE to be eligible for payment. National Medicare hospice rates will be used for reimbursement of each of the following levels of care provided by, or under arrangement with, a Medicare-approved hospice program:

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

The hospice will be reimbursed for the amount applicable to the type and intensity of the services furnished to the beneficiary on a particular day. One rate will be paid for each level of care except for continuous home care, which will be reimbursed based on the number of hours of continuous care furnished to the beneficiary on a given day. **Note:** Continuous home care must be equal to or greater than eight hours per day, midnight to midnight, with at least 50 percent of care provided by licensed practical nursing or registered nursing staff. The rates will be adjusted for regional differences using appropriate Medicare area wage indexes.

The national payment rates are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary’s terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice. The only amounts that will be allowed outside the locally adjusted national payment rates and not considered hospice services will be for direct patient care services rendered by an independent attending physician.

The hospice will bill for its physician charges/services (physicians under contract with the hospice program) on a UB-04 using the appropriate revenue code of 657 and the appropriate CPT codes. 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).

Independent attending physician services or patient care services rendered by a physician not under contract with or employed by the hospice are not considered a part of the hospice benefit and are not included in the cap amount calculations. The provider will bill for these services on a CMS-1500 using the appropriate CPT codes. These services will be subject to standard TRICARE reimbursement and cost-sharing/deductible provisions.

**Outpatient Prospective Payment System**

TRICARE OPPS was implemented on May 1, 2009, to pay claims filed for hospital outpatient services.

TRICARE OPPS is mandatory for both network and non-network providers and applies to all hospitals participating in the Medicare program, with some exceptions (e.g., CAHs, cancer hospitals, 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
  - Department of Veterans Affairs hospitals
  - Freestanding ASCs
  - Freestanding birthing centers
  - Freestanding end-stage renal disease facilities
  - Freestanding PHPs (psychiatric and substance use disorder rehabilitation facilities)
- HHAs
- Hospice programs
- Other corporate services providers (e.g., freestanding cardiac catheterization and sleep disorder diagnostic centers)
- SNFs

Temporary Transitional Payment Adjustments (TTPAs) are in place for all hospitals, both network and non-network, in order 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 Ambulatory Payment Classification (APC) codes for emergency room (ER) and hospital clinic visits (APC codes 604–609 and 613–616), with reductions in each transition year.

For non-network hospitals, the TTPAs cover a three-year period, with reductions in each transition year.

Figure 9.1 shows the TTPA percentages for APC codes 604–609 and 613–616 during the four-year network hospital and three-year non-network hospital transition periods.

### TTPA Percentages for APC Codes 604–609 and 613–616

<table>
<thead>
<tr>
<th>Transition Period</th>
<th>Network¹</th>
<th>Non-Network²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ER</td>
<td>Hospital</td>
</tr>
<tr>
<td>Year 1</td>
<td>200%</td>
<td>175%</td>
</tr>
<tr>
<td>Year 2</td>
<td>175%</td>
<td>150%</td>
</tr>
<tr>
<td>Year 3</td>
<td>150%</td>
<td>130%</td>
</tr>
<tr>
<td>Year 4</td>
<td>130%</td>
<td>115%</td>
</tr>
<tr>
<td>Year 5</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

1. The transition period for network hospitals is four years. In year 5, TRICARE’s payment level will be the same as Medicare’s (i.e., 100%).
2. The transition period for non-network hospitals is three years. In year 4, TRICARE’s payment level will be the same as Medicare’s (i.e., 100%).

OPPS implementation in rural areas for small hospitals with fewer than 100 beds and sole community hospitals will be delayed until January 1, 2010, when the Medicare transitional corridor payments for these hospitals expire.

For more information on OPPS implementation, refer to Chapter 13 of the TRICARE Reimbursement Manual, available at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil); visit [www.tricare.mil/opps](http://www.tricare.mil/opps); or contact Health Net at 1-877-TRICARE (1-877-874-2273).

### 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 9.2 on the following page.

DoD has adjusted the TRICARE reimbursement rates to mirror Medicare’s levels. Updated rates and weights are available at [www.tricare.mil/tma](http://www.tricare.mil/tma).
<table>
<thead>
<tr>
<th>Update Frequency</th>
<th>Rates Scheduled to Change</th>
</tr>
</thead>
</table>
| Variable at TMA’s discretion | • CMAC *(may be adjusted quarterly)*  
• Anesthesia  
• Injectables and immunizations |
| April 1 | • Birthing centers |
| October 1 | • DRG  
• Residential treatment centers  
• Mental health per diem  
• SNF PPS *(may be adjusted quarterly)*  
• Inpatient hospital copayments and cost-shares |
| November 1 | • Ambulatory surgery grouper |
| Quarterly (January, April, July, October) | • DMEPOS  
• Home health PPS  
• OPPS |
Frequently Asked Questions

1. What is a TRICARE Prime Service Area?
A TRICARE Prime Service Area is the geographic area where TRICARE Prime benefits are offered. This includes all Base Realignment and Closure Commission sites, a 40-mile radius around all military treatment facilities, and in predetermined areas.

2. Who determines TRICARE reimbursement rates?
Congress passed the Defense Appropriations Act establishing the uniform payment system for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), called the CHAMPUS maximum allowable charge (CMAC). When TRICARE was implemented, the TRICARE Enabling Statute [Title 10, United States Code, Section 1079(h)(1)] gave the Secretary of Defense the authority to set the reimbursement rates for health care services provided to TRICARE beneficiaries. Those rates are set in accordance with the same reimbursement rules that apply to payments for similar services under Medicare (Title XVIII of the Social Security Act [Title 42, United States Code, Section 1395]). Refer to the TRICARE Reimbursement Methodologies section of this handbook for more information. See “Glossary of Terms” later in this section for more information about CMAC versus TRICARE-allowable charges.

3. What types of procedures require prior authorization?
Procedures that require prior authorization vary by beneficiary type. Refer to the Health Care Management and Administration section of this handbook for more information about the rules for prior authorization and how to obtain a list of procedures requiring prior authorization. Providers can also access the Prior Authorization Determination Tool at www.healthnetfederalservices.com to determine current prior authorization requirements.

4. Does TRICARE provide case management?
Health Net Federal Services, LLC (Health Net) offers case management for beneficiaries with complex cases. See the Health Care Management and Administration section for more information.

5. How are maternity patients managed?
Military medicine focuses on family-centered care before, during, and after childbirth. Military treatment facilities in the North Region are committed to being responsive to maternity patients and flexible to their needs. They offer an extended military “family,” knowledgeable about the separation aspects of military life. The family-centered care approach ensures that new military families get the best possible personalized, coordinated care during this special time. Expectant mothers are encouraged to visit www.tricare.mil/familycare when deciding where to obtain their maternity care. Refer to the Medical Coverage section of this handbook for details on maternity care coverage.

6. Does TRICARE offer any programs for persons with disabilities?
Yes, the TRICARE Extended Care Health Option (ECHO) program provides additional benefits to certain beneficiaries. See details about TRICARE ECHO in the TRICARE Program Options section of this handbook.

7. Does TRICARE have any contracted laboratory services?
Health Net maintains a network of laboratory services in the North Region that can be viewed by accessing the network provider directory maintained on the Health Net Web site. Please direct TRICARE beneficiaries to one of the contracted laboratories. When submitting a requisition for a laboratory procedure, please include the appropriate diagnosis code. The code must be specific and consistent with services ordered or the claim will be denied.
8. **How does TRICARE define an emergency?**

An emergency is defined as a medical, maternity, or psychiatric condition that would lead a “prudent layperson” (someone with average knowledge of health and medicine) to believe that a serious medical condition existed 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 presents with severe pain.

9. **If a TRICARE Prime, TRICARE Prime Remote (TPR), or TRICARE Prime Remote for Active Duty Family Members (TPRADFM) patient (including active duty service members [ADSMs]) is admitted following emergency care, does that admission require prior authorization?**

Hospitals must notify Health Net within 24 hours or the next business day of an emergency inpatient admission. Fax the admission “face sheet” to the Prior Authorization fax line at 1-888-299-4181. Routine hospital admissions must also be approved by the primary care manager or the admission may be covered under the TRICARE Prime point of service option.

10. **Does TRICARE allow a 23-hour outpatient observation status?**

Physicians may evaluate, stabilize, and treat patients for whom a full admission is not clear by using the 23-hour outpatient observation status. If after 23 hours it becomes apparent that the patient must continue as an inpatient, authorization for the inpatient admission must be obtained. For details on how the TRICARE outpatient prospective payment system affects outpatient observation stays, refer to Chapter 13 of the TRICARE Reimbursement Manual at http://manuals.tricare.osd.mil.

11. **Do TRICARE Prime, TPR, and TPRADFM beneficiaries have coverage out of this region?**

True emergencies are covered for TRICARE Prime, TPR, and TPRADFM beneficiaries traveling away from home, whether they are in or out of their TRICARE region. Health Net must be notified within 24 hours or the next business day of an emergency inpatient hospital admission. Nonemergency care must be approved by the beneficiary’s primary care manager and authorized by Health Net when necessary to ensure maximum TRICARE coverage. Routine care for TRICARE Prime, TPR, and TPRADFM enrollees may be covered under the point of service option.

12. **Where does my office file TRICARE claims?**

PGBA, LLC, is Health Net’s partner for claims processing. Note: TRICARE For Life claims are processed by Wisconsin Physicians Service. Refer to the Claims Processing and Billing Information section of this handbook for more information on filing claims.

13. **How do I order current TRICARE marketing and educational materials?**

Providers can view the latest TRICARE materials, including manuals and TRICARE Provider News publications, through the Health Net Web site at www.healthnetfederalservices.com. For a printed copy of a specific material, call Health Net at 1-877-TRICARE (1-877-874-2273).
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<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
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<td>ABA</td>
<td>Applied behavior analysis</td>
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<td>ADDP</td>
<td>Active Duty Dental Program</td>
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<td>ADFM</td>
<td>Active duty family member</td>
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<td>ADSM</td>
<td>Active duty service member</td>
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<tr>
<td>ASC</td>
<td>Ambulatory surgery center</td>
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<td>BCAC</td>
<td>Beneficiary Counseling and Assistance Coordinator</td>
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<td>BRAC</td>
<td>Base Realignment and Closure Commission</td>
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<td>CHAMPUS</td>
<td>Civilian Health and Medical Program of the Uniformed Services (now called TRICARE)</td>
</tr>
<tr>
<td>CHAMPVA</td>
<td>Civilian Health and Medical Program of the Department of Veterans Affairs (Veterans Affairs health care program for patients)</td>
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<td>CCTP</td>
<td>Custodial Care Transition Program</td>
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<td>CHCBP</td>
<td>Continued Health Care Benefit Program</td>
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<tr>
<td>CLR</td>
<td>Clearly legible report</td>
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<tr>
<td>CMAC</td>
<td>CHAMPUS maximum allowable charge</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services (formerly HCFA)</td>
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<td>COB</td>
<td>Coordination of benefits</td>
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<td>CPT</td>
<td>Current Procedural Terminology</td>
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<td>DCAO</td>
<td>Debt Collection Assistance Officer</td>
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<td>DEERS</td>
<td>Defense Enrollment Eligibility Reporting System</td>
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<td>DME</td>
<td>Durable medical equipment</td>
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<tr>
<td>DMEPOS</td>
<td>Durable medical equipment, prosthetics, orthotics, and supplies</td>
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<tr>
<td>DoD</td>
<td>Department of Defense</td>
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<tr>
<td>DRG</td>
<td>Diagnosis-related group</td>
</tr>
<tr>
<td>DTF</td>
<td>Dental treatment facility</td>
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<tr>
<td>ECHO</td>
<td>Extended Care Health Option</td>
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<td>EFMP</td>
<td>Exceptional Family Member Program</td>
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<td>EFT</td>
<td>Electronic funds transfer</td>
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<td>Employee identification number</td>
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<td>EOB</td>
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<td>ESRD</td>
<td>End-stage renal disease</td>
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<td>FDA</td>
<td>U.S. Food and Drug Administration</td>
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<td>HBA</td>
<td>Health benefits advisor</td>
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<td>HCFA</td>
<td>Health Care Financing Administration (now CMS)</td>
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<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
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<tr>
<td>ICD-9</td>
<td>International Classification of Diseases, Ninth Revision</td>
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<tr>
<td>ID</td>
<td>Identification</td>
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<tr>
<td>IVR</td>
<td>Interactive Voice Response</td>
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<tr>
<td>MCSC</td>
<td>Managed care support contractor</td>
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<tr>
<td>MHS</td>
<td>Military Health System</td>
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<tr>
<td>MMSO</td>
<td>Military Medical Support Office</td>
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<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
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<tr>
<td>MTF</td>
<td>Military treatment facility</td>
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<tr>
<td>NAS</td>
<td>Nonavailability statement</td>
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<td>NATO</td>
<td>North Atlantic Treaty Organization</td>
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<td>NCI</td>
<td>National Cancer Institute</td>
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<td>NDC</td>
<td>National Drug Code</td>
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<td>NOAA</td>
<td>National Oceanic and Atmospheric Administration</td>
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<td>NPI</td>
<td>National Provider Identifier</td>
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<td>NQMC</td>
<td>National Quality Monitoring Contractor</td>
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<td>OHI</td>
<td>Other health insurance</td>
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<td>OPSS</td>
<td>Outpatient prospective payment system</td>
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<td>PCM</td>
<td>Primary care manager</td>
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<td>PDTS</td>
<td>Pharmacy Data Transaction Service</td>
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<td>PGBA</td>
<td>PGBA, LLC</td>
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<td>PHP</td>
<td>Partial hospitalization program</td>
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<td>PHS</td>
<td>Public Health Service</td>
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<td>POS</td>
<td>Point of service</td>
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<tr>
<td>PPO</td>
<td>Preferred provider organization</td>
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<tr>
<td>PPS</td>
<td>Prospective payment system</td>
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<td>RTC</td>
<td>Residential treatment center</td>
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<tr>
<td>SHCP</td>
<td>Supplemental Health Care Program</td>
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<tr>
<td>SNF</td>
<td>Skilled nursing facility</td>
</tr>
<tr>
<td>SPOC</td>
<td>Service point of contact</td>
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<tr>
<td>SSN</td>
<td>Social Security number</td>
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<tr>
<td>SUDRF</td>
<td>Substance use disorder rehabilitation facility</td>
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<td>TAMP</td>
<td>Transitional Assistance Management Program</td>
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<td>TDP</td>
<td>TRICARE Dental Program</td>
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<td>TRICARE For Life</td>
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<td>TRICARE Management Activity</td>
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<td>TRICARE Prime Remote</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>TPRADFM</td>
<td>TRICARE Prime Remote for Active Duty Family Members</td>
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<td>TRDP</td>
<td>TRICARE Retiree Dental Program</td>
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<td>TRICARE Regional Office</td>
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<td>TRICARE Service Center</td>
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<td>United States</td>
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<td>US Family Health Plan</td>
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<td>USPHS</td>
<td>United States Public Health Service</td>
</tr>
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<td>VA</td>
<td>Department of Veterans Affairs</td>
</tr>
<tr>
<td>WPS</td>
<td>Wisconsin Physicians Service</td>
</tr>
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Glossary of Terms

Abuse
The improper or excessive use of program benefits, resources, or services by a provider or beneficiary. Abuse can be either intentional or unintentional and can occur when:

- Excessive or unnecessary services are used.
- Services are not appropriate for the beneficiary’s condition.
- A beneficiary uses an expired or voided identification card.
- A more expensive treatment is rendered when a less expensive treatment would be as effective.
- A provider or beneficiary files false or incorrect claims.
- Billing or charging does not conform to TRICARE requirements.

Accepting Assignment
Accepting assignment refers to those instances when a provider agrees to accept the TRICARE-allowable charge(s).

Allowable Charge Review
An allowable charge review is a method by which a network provider may request a review of a claim he or she deems was paid at an inappropriate level.

Appeals Review
Method by which a non-network participating provider (i.e., one who has accepted assignment) may request a review of a denial of benefit coverage for services provided or proposed that are deemed not medically necessary.

Authorization
A review determination made by a licensed professional nurse or other health care professional for requested services, procedures, or admissions. Authorizations must be obtained prior to services being rendered or within 24 hours of an emergency admission.

Authorized Provider
See the definition for TRICARE-authorized provider.

Balance Billing
A term used to describe when a provider bills a beneficiary for the difference between billed charges and the TRICARE-allowable charge after TRICARE (and other health insurance) has paid everything it is going to pay. Network providers are prohibited from balance billing.

Base Realignment and Closure Commission (BRAC) Site
A military base that has been closed or targeted for closure by the government’s BRAC.

Beneficiary
A beneficiary is a person who is eligible for TRICARE benefits. Beneficiaries include active duty family members and retired service members and their families. Family members include spouses and unmarried natural children or stepchildren up to the age of 21 (or 23 if full-time students at accredited institutions of learning). Other beneficiary categories are listed in the TRICARE Eligibility section.

Beneficiary Counseling and Assistance Coordinators (BCACs)
Persons at military treatment facilities and TRICARE Regional Offices who are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining medical care through TRICARE. BCACs were previously known as Health Benefits Advisors, or HBAs. To locate a BCAC, visit www.tricare.mil/bcacdcao.

Care Coordination
An approach to care management using proactive methods to optimize health outcomes and reduce risks of future complications over a short-term (two to six weeks) single episode of care. Prospective and concurrent reviews are used to identify current and future beneficiary needs.

Case Management
A collaborative process normally associated with multiple episodes of health care intervention that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet a beneficiary’s complex health needs. This is accomplished through communication and available resources that promote quality, cost-effective outcomes.
**Catastrophic Cap**
The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given fiscal year (October 1–September 30). Point of service (POS) cost-shares and the POS deductible are not applied to the catastrophic cap.

**Centers for Medicare and Medicaid Services**
The federal agency that oversees all aspects of health care claims filing for Medicare (formerly known as the Health Care Financing Administration).

**Certified Provider**
See the definition for TRICARE-authorized provider.

**CHAMPUS Maximum Allowable Charge (CMAC)**
The maximum amount TRICARE will cover for nationally established fees (i.e., fees for professional services). CMAC is the TRICARE-allowable charge for covered services when appropriately applied to services priced under CMAC.

**Circumvention**
A term used to describe inappropriate medical practices or actions that result in unnecessary multiple admissions of an individual.

**Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)**
The former health care program established to provide health care coverage for active duty family members and retirees and their family members. TRICARE was organized as a separate office under the Assistant Secretary of Defense and replaced CHAMPUS in 1994. Benefits covered under CHAMPUS are now covered under TRICARE Standard.

**Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)**
CHAMPVA is the federal health benefits program for family members of 100-percent totally and permanently disabled veterans. CHAMPVA is also available to eligible beneficiaries under age 65. CHAMPVA is administered by the Department of Veterans Affairs and is not associated with the TRICARE program. For questions regarding CHAMPVA, call 1-800-733-8387 or e-mail ha.inq@va.gov.

**ClaimCheck®**
A customized, automated claims auditing system that verifies the clinical accuracy of professional claims.

**Clearly Legible Report**
For care referred from a military treatment facility to a civilian network provider, network providers must provide clearly legible reports, operative reports, and discharge summaries to the initiating provider within seven business days of the beneficiary’s care. Visit the Health Net Web site at www.healthnetfederalservices.com for current information regarding the submission of clearly legible reports.

**CMS-1500**
As of January 1, 2008, the National Uniform Claim Committee required the use of the Centers for Medicare and Medicaid Services (CMS) Health Insurance Claim Form (version 08/05) to accommodate the reporting of the National Provider Identifier. The December 1990 version of the CMS-1500 claim form was discontinued and only the revised form is to be used after December 31, 2007. All rebilling of claims must use the revised form from January 1, 2008, forward, even though earlier submissions may have been on the December 1990 version of the CMS-1500 claim form.

**Concurrent Review**
A review performed during the course of a beneficiary’s inpatient admission with the purpose of validating the appropriateness of the admission, level of care, medical necessity, and quality of care, as well as the information provided during earlier reviews. Additional functions performed include screening for case management and identification of discharge planning needs. The review may be conducted by telephone or on site. Concurrent reviews are generally performed when TRICARE is the primary payer. Concurrent reviews that indicate criteria are not met are referred for medical director review.
**Copayment**
The fixed amount a TRICARE Prime program option enrollee will pay for care in the civilian provider network. Active duty family members enrolled in a TRICARE Prime program option are not required to make copayments.

**Corporate Services Provider**
A class of TRICARE-authorized providers consisting of institutional-based or freestanding corporations and foundations that render professional ambulatory or in-home care and technical diagnostic procedures.

**Cost-Share**
The percentage of the allowable charges a beneficiary will pay under TRICARE Standard, TRICARE Extra, or TRICARE Reserve Select. The cost-share depends on the sponsor’s status—active duty or retired. **Note:** Extended Care Health Option services also have cost-shares, regardless of the beneficiary’s program option (including TRICARE Prime).

**Credentialed**
The process that evaluates and subsequently allows providers to participate in the TRICARE network. This includes a review of the provider’s training, educational degrees, licensure, practice history, etc.

A systematic listing and coding of procedures and services performed by physicians. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physician is accurately identified.

**Deductible**
The annual amount a TRICARE Standard, TRICARE Extra, or TRICARE Reserve Select beneficiary must pay for covered outpatient benefits before TRICARE begins to share costs. TRICARE Prime beneficiaries do not have an annual deductible, unless they are utilizing their point of service option.

**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 U.S. assigned to provide care to eligible USFHP beneficiaries—including those who are age 65 and older—who live within the DP area. At these DPs, the USFHP provides TRICARE Prime benefits and cost-shares for eligible persons who enroll in USFHP, including those who are Medicare eligible.

**Diagnosis-Related Group**
A reimbursement methodology used for inpatient care in some hospitals.

**Discharge Planning**
A process that assesses requirements and the coordination of care for a beneficiary’s timely discharge from an acute inpatient setting to a post-care environment without need for additional military treatment facility or civilian provider assistance.

**Disease Management**
A prospective, disease-specific approach to improving health care outcomes by providing education to beneficiaries through non-physician practitioners who specialize in targeted diseases.

**Enrollee**
A TRICARE beneficiary who has elected to enroll in a TRICARE program option (e.g., TRICARE Prime, TRICARE Prime Remote, TRICARE Prime Remote for Active Duty Family Members).

**Explanation of Benefits**
A statement sent to a beneficiary and the provider showing that a claim was processed and indicates the amount paid to the provider. If denied, an explanation of denial is provided.
**Extended Care Health Option (ECHO)**
ECHO is a supplemental program to the TRICARE basic program. It provides eligible active duty family members with an additional financial resource for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the beneficiary’s qualifying condition. Qualifying conditions may include moderate or severe mental retardation, a serious physical disability, or an extraordinary physical or psychological condition such that the beneficiary is homebound.

**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 six or nine. TRICARE will not issue an authorization for treatment or services to NATO beneficiaries without a valid FIN.

**Fraud**
An instance in which deliberate deceit is used by a provider to obtain payment for services not actually delivered or received, or by a beneficiary to claim program eligibility.

**Grievance**
A grievance is a written complaint or concern from a TRICARE beneficiary or a provider on a non-appealable issue. Grievances address issues of perceived failure by any member of the health care delivery team—including TRICARE military providers, Health Net, or Health Net subcontractor personnel—to provide appropriate and timely health care services, access to care, quality of care, or level of care or service to which the beneficiary or provider feels they are entitled.

**Health Care Financing Administration**
The former name of the federal agency that oversees all aspects of health claims filing for Medicare. The agency is now known as the Centers for Medicare and Medicaid Services.

**Health Management Strategies International**
A company that has developed behavioral health review criteria for medical necessity reviews.

**Healthcare Common Procedure Coding System (HCPCS)**
A set of codes used by Medicare that describes services and procedures. HCPCS includes Current Procedural Terminology (CPT) codes for services not included in the normal CPT code list, such as durable medical equipment and ambulance service. While HCPCS is nationally defined, there is a provision for local use of certain codes.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
HIPAA was introduced to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to simplify the administration of health insurance; and for other purposes.

**Initial Denial**
Made only after second-level review if the care or treatment is not found to be medically necessary, reasonable, or at the appropriate level. The non-network, participating provider or beneficiary may appeal the initial denial. For more information, see the definition for second-level review.

**Managed Care**
A concept under which an organization delivers health care to enrolled members and controls costs by closely supervising and reviewing the delivery of health care.

**Managed Care Support Contractor (MCSC)**
A civilian health care partner of the Military Health System that administers TRICARE in one of the TRICARE regions. An MCSC—Health Net Federal Services, LLC is an MCSC—helps combine the services available at military treatment facilities with those offered by the TRICARE network of civilian hospitals and providers to meet the health care needs of TRICARE beneficiaries.

**Medical Emergency**
A medical condition manifesting itself by acute symptoms of sufficient severity—including severe pain—such that a prudent layperson could reasonably expect the absence of medical
attention to result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. In the case of a pregnant woman, the danger should be considered to adversely affect the health of the woman or her unborn child.

**Medically Necessary**
Appropriate and necessary treatment of the beneficiary’s illness or injury according to accepted standards of medical practice and TRICARE policy. Medical necessity must be documented in clinical notes.

**Military Treatment Facility (MTF)**
An MTF is a medical facility (hospital, clinic, etc.) owned and operated by the uniformed services and usually located on or near a military base.

**National Drug Code (NDC)**
The U.S. Food and Drug Administration (FDA) requires companies engaged in the manufacture, preparation, propagation, compounding, or processing of a drug product to register with the FDA and provide a list of all drugs manufactured for commercial distribution. Drug products are identified and reported using a unique three-segment number called the NDC. NDCs can be found on the Drug Registration and Listing System published by the FDA.

**National Guard and Reserve**
The National Guard and Reserve includes the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the Coast Guard Reserve.

**National Provider Identifier (NPI)**
The NPI is a 10-digit number used to identify providers in standard electronic transactions. It is a requirement of the Health Insurance Portability and Accountability Act of 1996.

**Network Provider**
A network provider is a professional or institutional provider who has a contractual relationship with the managed care support contractor to provide care at a contracted rate. A network provider agrees to file claims and handle other paperwork for TRICARE beneficiaries, and typically administers care to TRICARE Prime beneficiaries and those TRICARE Standard beneficiaries using TRICARE Extra (the preferred provider option). A network provider accepts the negotiated rate as payment in full for services rendered.

**Nonavailability Statement**
A nonavailability statement is a certification from a military treatment facility stating that a specific health care service or procedure cannot be provided.

**Non-Network Provider**
A non-network provider is one who has no contractual relationship with the managed care support contractor, but is authorized to provide care to TRICARE beneficiaries. There are two types of non-network providers—participating and nonparticipating.

**Nonparticipating Provider**
A nonparticipating provider is a TRICARE-authorized hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to TRICARE beneficiaries but who has not signed a contract and does not agree to accept the TRICARE-allowable charge or file claims for TRICARE beneficiaries.

**North Atlantic Treaty Organization (NATO) Member**
A member of a foreign NATO nation’s armed forces who is on active duty and who, in connection with official duties, is stationed in or passing through the United States. The foreign NATO nations are Belgium, Bulgaria, Canada, Czech Republic, Denmark, Estonia, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Turkey, and the United Kingdom.

**Other Health Insurance (OHI)**
Any non-TRICARE health insurance that is not considered a supplement is considered OHI. This insurance is acquired through an employer, entitlement program, or other source. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian

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Outpatient Prospective Payment System (OPPS)
TRICARE OPPS is used to pay claims for hospital outpatient services. TRICARE OPPS is based on nationally established Ambulatory Payment Classification payment amounts and standardized for geographic wage differences that include operating and capital-related costs, which are directly related and integral to performing a procedure or furnishing a service in a hospital outpatient department. TRICARE OPPS became effective May 1, 2009.

Participating Provider
A provider who has agreed to file claims for TRICARE beneficiaries, accept payment directly from TRICARE, and accept the TRICARE-allowable charge as payment in full for services received. Non-network providers may participate on a claim-by-claim basis. Providers may seek payment of applicable copayments, cost-shares, and deductibles from the beneficiary. After May 1, 2009, under the TRICARE outpatient prospective payment system, all hospitals that are Medicare-participating providers must, by law, also participate in TRICARE for inpatient and outpatient care. Refer to Chapter 13 of the TRICARE Reimbursement Manual at http://manuals.tricare.osd.mil for additional details on OPPS.

Peer Review Organization
An organization charged with reviewing provider quality and medical necessity.

Per Diem
A reimbursement methodology based on a per-day rate that is currently used for behavioral health institutions and partial hospitalization programs.

Point of Service (POS)
An option that allows a TRICARE Prime or TRICARE Prime Remote for Active Duty Family Members beneficiary to obtain medically necessary services—inside or outside the TRICARE network—from someone other than his or her primary care manager without first obtaining a referral or authorization. Utilizing the POS option results in a deductible and greater out-of-pocket expenses for the beneficiary. The POS option is not available to active duty service members.

Pre-Authorization
See the definition for prior authorization.

Preferred Provider Organization (PPO)
A network of health care providers who provide services to patients at discounted rates or cost-shares. TRICARE Extra is considered to be a PPO option.

Primary Care Manager (PCM)
A TRICARE civilian network provider or military treatment facility (MTF) provider who provides primary care services to TRICARE beneficiaries. A PCM is either selected by the beneficiary or assigned by an MTF commander or his or her designated appointee.

* TRICARE Prime Remote beneficiaries may choose a TRICARE-authorized provider if a network provider is not available.

Prime Service Area (PSA)
A PSA is an area that has been defined and mapped in proximity to military treatment facilities (MTFs), Base Realignment and Closure Commission (BRAC) installations, and in other predetermined areas. Minimum government standards for MTF PSAs and BRAC PSAs are geographically defined by ZIP codes that create an approximate 40-mile radius from the MTF or BRAC installation.

Prior Authorization
A process of reviewing certain medical, surgical, and behavioral health care services to ensure medical necessity and appropriateness of care prior to services being rendered or within 24 hours of an emergency admission.

Prospective Review
A screening process used to evaluate the medical necessity and appropriateness of a treatment or service proposed. The review is prospective (before the care or service is performed) and criteria-based using InterQual®. A registered nurse, physician assistant, behavioral health clinician, or physician performs reviews. A first-level (i.e., prospective) review may result
in an authorization of services or in a referral to second-level review. A first-level review never results in a denial of care or treatment.

**Protected Health Information (PHI)**
PHI is any individually identifiable health information that relates to a patient’s past, present, or future physical or mental health and related health care services. PHI may include demographics, documentation of symptoms, examination and test results, diagnoses, and treatments.

**Reconsideration or Appeal**
A formal written request by an appropriate appealing party or an appointed representative to resolve a disputed statement of fact.

**Referral**
The process of sending a patient to another professional provider (physician or psychologist) for consultation or a health care service that the referring source believes is necessary but is not prepared or qualified to provide. Referrals are required for most services for TRICARE Prime beneficiaries. Referrals are always required for active duty service members (except in the case of an emergency) for services provided by a civilian provider, other than the primary care manager.

**Region**
A geographic area determined by the federal government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

**Resource Sharing Agreement (RSA)**
There are two types of RSAs. External RSAs are arrangements that allow military providers to render medical services to TRICARE beneficiaries in civilian network medical facilities. Internal RSAs are arrangements that allow civilian providers into the military treatment facility system to render medical services to TRICARE beneficiaries.

**Retrospective Review**
A review of a beneficiary’s medical record that occurs after the services have been rendered.

**Second-Level Review**
Cases that do not meet the prospective review screening criteria are referred for medical director review at the second level.

**Social Security Number (SSN)**
An SSN is a number assigned by the federal government for the purposes of identifying a specific individual and taxpayer.

**Split Enrollment**
Refers to multiple family members enrolled in TRICARE Prime under different TRICARE regions or managed care support contractors.

**Sponsor**
The sponsor is the active duty service member or retiree through whom family members are eligible for TRICARE.

**Supplemental Health Care Program (SHCP)**
The SHCP is a program for eligible uniformed services members and other designated patients who require medical care that is not available at the military treatment facility (MTF). Because services are not available at the MTF, these beneficiaries must be referred to a civilian provider.

**Supplemental Insurance**
Supplemental insurance includes health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance plans, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

**Tax Identification Number (TIN)**
A TIN is a number assigned by the state in which a business or entity is operated that identifies it for filing and paying taxes related to the business or entity.
Transitional Care
Transitional care is a program that is designed for all beneficiaries to assure a coordinated approach takes place across the continuum of care.

Treatment Plan
A treatment plan is a multidisciplinary care plan for each beneficiary in active case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, military resources, all funding options, treatment goals, and assessment of the beneficiary environment. The plan is updated monthly and modified when appropriate. These plans are developed in collaboration with the attending physician and beneficiary or guardian.

TRICARE-Allowable Charge
The TRICARE-Allowable charge (also called allowable charge) is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The allowable charge is normally the lesser of the actual billed charge and the allowable charge. For example, if the allowable charge for a service is $90 and the billed charge is $50, TRICARE will pay $50 (actual billed charge); if the billed charge is $100, TRICARE will pay $90 (the allowable charge). In the case of inpatient hospital payments, the diagnosis-related group rate is the TRICARE-Allowable charge, regardless of the billed amount. For network providers, the allowable charge is the lesser of the contracted rate and the maximum amount TRICARE would authorize if the service had been furnished by a non-network participating provider.

TRICARE-Authorized Provider
A provider who meets TRICARE’s licensing and certification requirements and has been authorized by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (such as laboratory and radiology providers) and pharmacies.

TRICARE Prime Service Area
See the definition for Prime Service Area.

UB-04
The CMS-1450 form (also known as the UB-92) has been replaced with the UB-04 form. The UB-04 form is used by hospitals and other institutional providers to bill government and commercial health plans; it must be used exclusively for institutional billing beginning January 1, 2008. The UB-04 data set accommodates the National Provider Identifier and incorporates a number of other important changes and improvements. It is also HIPAA-compliant.

Urgent Care
Urgent care is medically necessary treatment that is required for an illness or injury that would not result in further disability or death if not treated immediately. The illness or injury does require professional attention, and should be treated within 24 hours to avoid development of a situation in which further complications could result if treatment is not received.
Forms

Samples of the Health Insurance Claim Form (CMS-1500) and the Uniform Bill Form (UB-04) are illustrated on the following pages.

The following forms may be found at www.healthnetfederalservices.com. If a form is not found on the Web site, contact a Health Net representative at 1-877-TRICARE (1-877-874-2273).

- An Important Message from TRICARE
- Appointment of Representative and Authorization to Disclose Information Form
- Authorization to Disclose Information Form
- Statement of Personal Injury—Possible Third Party Liability Form (DD Form 2527)
- TRICARE Other Health Insurance Questionnaire
- TRICARE Service Request/Notification Form
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal offense punishable under state and/or federal laws and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature authorizes payment to be made and authorizes release of any information necessary to process the claim and certifies that the information provided in section 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare and/or other insurance companies, including employers, state and/or federal agencies, and the patient has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.34(e). If the claim is completed, the patient's signature authorizes release of the information to the health plan or agency shown in the Medicare assigned or CHAMPUS policy case. In the case of a self-pay patient, the physician agrees to assume the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payments to health benefit providers through certain affiliations with the Uniformed Services. Information on the patient's spouse should be provided in those items captioned as "Insured," i.e., items 4, 5, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedures and diagnostic coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were properly furnished by the person(s) authorized to render professional services to any employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare of CHAMPUS regulations.

For services to be considered as "incident to a physician's professional service," 1) they must be rendered under the physician's immediate personal supervision by his employees; 2) they must be integral, although incidental use of other physician's services is allowed; 3) the chief medical reviewer's office, and 4) the services of other physicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that (a) the services were rendered to any active duty member of the Uniformed Services, or civilian employee of the United States Government on a contract or similar basis, and (b) the services were performed for a Black Lung-related disability.

No Part 5 Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 140.2).

NOTE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

We are authorized by CMS, CHAMPUS, and OICP to ask for information necessary to the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information in section 205(c), 1857, 1877 and 1874 of the Social Security Act, as amended, 42 CFR 411.34(e) and 414.34(e) and 42 U.S.C. 718 are in section 9051 of Title V of the Social Security Act. We are required to use this information to properly determine to whom our services will be paid. The information we obtain in completing a claim under this program is used to determine eligibility and to determine the amount of money you are owed. It is used to determine if the services and supplies you receive are covered by this program and/or if further payment is needed.

The information may also be given to other providers of services and supplies, intermediaries, qualified independent contractors, state and local agencies, the states, and other Federal agencies, to obtain active administration of CHAMPUS programs that require reimbursement to third parties by Federal programs, and as otherwise necessary to administer these programs. For example, if you may be necessary to check information on your social security number to determine eligibility. Additional disclosures are made through routine uses for information contained in systems of records.


CHAMPUS CLAIMS (PROFESSIONAL CLAIMS)

To be eligible for medical care provided by civilian sources to issue payment on an establishment of eligibility and determinations that the services properly received or authorized by law.

ROUTETOUS(USO) Information and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory duties and responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in connection with the Internal Revenue Service determination of tax liability; and to Congress insofar as it has a statutory or non-statutory role as a responsible agency, and consumer reporting agencies in connection with personnel qualification or personnel services for which the Secretary of Defense has delegated responsibility.

Charges, adjustments, and collections are to be made to the patient, other insurance carriers, employers, and individual providers of care, as required under law.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may require. In the event of noncompliance with the amount paid by Medicaid, for those services for which payment under that program, with the exception of authorized deductible, co-payment, co-payment or similar cost-sharing change.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): By signing this form above I certify that I was medically indicated and necessary for the health of the patient and that the services were performed for a Black Lung-related disability.

NOTE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and recertification of this claim will be Federal and State funds, and that false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Department of Health and Human Services, 49 no person is required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0651. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review the instructions, search existing data sources, gather the data needed, and complete and review the information collection. You have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to; CMS, Attn: PPA Reports Clearance Officer, 7501 Security Boulevard, Baltimore, Maryland 21244-3000. For individuals seeking assistance, DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.
Health Insurance Claim Form (CMS-1500) Instructions

Claims must be submitted on the CMS-1500 for professional services. The following information is **required** on every claim:

**BOX 1** Indicate that this is a TRICARE claim by checking the box under “TRICARE CHAMPUS.”

**BOX 1a** Sponsor’s Social Security number. The sponsor is the person that qualifies the patient for TRICARE benefits.

**BOX 2** Patient’s name

**BOX 3** Patient’s date of birth and sex

**BOX 4** Sponsor’s full name. Do not complete if “self” is checked in **BOX 6**.

**BOX 5** Patient’s address including ZIP code. This must be a physical address. Post office boxes are not acceptable.

**BOX 6** Patient’s relationship to sponsor

**BOX 7** Sponsor’s address including ZIP code

**BOX 8** Marital and employment status of patient

**Note:** Box 11d should be completed prior to determining the need for completing Boxes 9a through 9d. If Box 11d is checked “Yes,” Boxes 9a and 9d must be completed. In addition, if there is another insurance carrier, the mailing address of that insurance carrier must be attached to the claim form.

**BOX 9** Full name of person with other health insurance (OHI) that covers patient

**BOX 9a** Other insured’s policy or group number

**BOX 9b** Other insured’s date of birth and sex (Not required, but preferred)

**BOX 9c** Other insured’s employer name or name of school

**BOX 9d** Name of insurance plan or program name where individual has OHI

**BOX 10a-c** Check to indicate whether employment or accident related. 
*(In the case of an auto accident, indicate the state where it occurred.)*

**Note:** Box 11 through Box 11c questions pertain to the sponsor.

**BOX 11** Indicate policy group or Federal Employees Compensation Act (FECA) number (if applicable).

**BOX 11a** Sponsor’s date of birth and sex, if different than **BOX 3**

**BOX 11b** Sponsor’s branch of service

**BOX 11c** Indicate “TRICARE” in this field.

**BOX 11d** Indicate if there is another health insurance plan primary to TRICARE in this field.

**BOX 12** Patient’s or authorized person’s signature and date; release of information. A signature on the file is acceptable provided signature is updated annually.

**BOX 13** Insured’s or Authorized Person’s Signature. This authorizes payment to the physician or supplier.

**BOX 14** Date of current illness or injury/Date of pregnancy (Required for injury or pregnancy)

**BOX 15** First date (MM/DD/YY) had same or similar illness (Not required, but preferred)

**BOX 16** Dates patient unable to work (Not required, but preferred)

**BOX 17** Name of referring physician (Very important to include this information)

**BOX 17a** Identification (non-NPI) number of referring physician with qualifier

**BOX 17b** Referring physician NPI

**BOX 18** Admit and discharge date of hospitalization

**BOX 19** Referral number

**BOX 20** Check if lab work was performed outside the physician’s office and indicate charges by the lab. If an outside provider (e.g., laboratory) performs a service, claims should include modifier “90” or indicate “Yes” in this block.

**BOX 21** Indicate at least one, and up to four, specific diagnosis codes.

**BOX 22** Prior authorization number

**BOX 23** Date of service

**BOX 24A** Place of service

**BOX 24B** EMG (emergency) indicator

**BOX 24C** CPT/HCPCS procedure code with modifier, if applicable

**BOX 24D** Diagnosis code reference number (pointer)

**BOX 24E** Charges for listed service

**BOX 24F** Days or units for each line item
BOX 24H  Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) related services/Family planning response and appropriate reason code (if applicable)

BOX 24I  Qualifier identifying if the number is a non-NPI ID

BOX 24J  Rendering Provider ID number. Enter the non-NPI ID number in the shaded area. Enter the NPI number in the unshaded area.

BOX 25  Physician’s/Supplier’s Tax Identification Number

BOX 26  Patient’s Account Number (Not required, but preferred)

BOX 27  Indicate whether provider accepts TRICARE assignment.

BOX 28  Total charges submitted on claim

BOX 29  Amount paid by patient or other carrier

BOX 30  Amount due after other payments are applied (Required if OHI)

BOX 31  Authorized signature

BOX 32  Name and address where services were rendered. This must be the actual physical location. If you use an independent billing service, please do not use the billing service’s address.

BOX 32a  NPI of the service facility location

BOX 32b  Two-digit qualifier identifying the non-NPI number followed by the ID number (if necessary)

BOX 33  Physician’s/Supplier’s billing name, address, ZIP code, and phone number

BOX 33a  NPI of billing provider

BOX 33b  Two-digit qualifier identifying the non-NPI number followed by the ID number (if necessary)

**CMS-1500 Place of Service Codes**

- 11 Office
- 12 Home
- 15 Mobile unit
- 21 Inpatient hospital
- 22 Outpatient hospital
- 23 Emergency room—hospital
- 24 Ambulatory surgical center
- 25 Birthing center
- 26 Military treatment facility
- 31 Skilled nursing facility
- 32 Nursing facility
- 33 Custodial care facility
- 34 Hospice
- 41 Ambulance, land
- 42 Ambulance, air or water
- 51 Inpatient psychiatric facility
- 52 Psychiatric facility, partial hospitalization
- 53 Community mental health center
- 54 Intermediate care center/mentally retarded
- 55 Residential substance abuse treatment facility
- 56 Psychiatric residential treatment center
- 61 Comprehensive inpatient rehabilitation facility
- 62 Comprehensive outpatient rehabilitation facility
- 65 End-stage renal disease treatment facility
- 71 State or local public health clinic
- 72 Rural health clinic
- 81 Independent laboratory
- 99 Other unlisted facility

**North Region Service Codes**

- Ambulance Services: F
- Anesthesia: 4
- Anesthesia Exception: 6
- Assistant at Surgery: 0
- Behavioral Health: C
- Birthing Center: S
- Consultation: 9
- Darbepoetin: 6
- Durable Medical Equipment: G—Purchase; or H—Rental
- Epoetin Alpha Injection Codes: 6
- Home Infusion Therapy: G
- Injections: 6
- Maternity: 3
- Medical: 6
- Mobile Health Providers: 5
- Neurology: 6 or P
- Orthotic/Prosthetic Procedures: G
- Pathology/Laboratory: P or 8
- Physical Therapy: D
- Radiation Oncology: E
- Radiation Therapy: P or E
- Radiology: P or 5
- Supplies: G
- Surgery: 2
1 | Uniform Bill Form (UB-04), page 1

**SAMPLE—Do not use.**

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</table>
UB-04 NOTICE:  THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAYポンDEN TO FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAWS.

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured/beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.

5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1395, 42 CFR 424.35, 10 USC 1071 through 1086, 32 CFR 195), and any other applicable contract regulations, is on file.

6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/hers claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill, Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.

9. For TRICARE Purposes:

(a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

(b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such facility a copy of Non-Availability Statement (DD Form 1271) is on file, or the physician has certified to a medical emergency in any instance where a copy of Non-Availability Statement is not filed.

(c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim. The provider certifies that coverage which is exclusive of supplemental payments to TRICARE-determined benefits.

(d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits.

(e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and

(f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2102), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, members of the Uniformed Services do not apply to TRICARE participating members of the Uniformed Services not on active duty.

(g) Based on 42 United States Code 1805a(n)[11g] all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1967; and

(h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible. If any paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.hubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS.
**Uniform Bill Form (UB-04) Instructions**

The following listing of UB-04 form locators is a summary of the Form Locator information.

**FL 1** Provider name, physical address and telephone number **required**

**FL 2** Pay-to Name and Address **required**

**FL 3a** Patient Control Number

**FL 3b** Medical/Health Record Number

**FL 4** Type of Bill (*Three-character alphanumeric identifier*)

**FL 5** Federal Tax Identification Number

**FL 6** Statement Covers Period (*From-Through*). The beginning and ending dates of the period included on the bill are shown in numeric fields (*MM-DD-YY*).

**FL 7** Not Required

**FL 8a-b** Patient’s Name (Surname first, first name, and middle initial, if any). Enter the patient’s SSN in field “a.” Enter the patient’s name in field “b.”

**FL 9a-e** Patient’s address including ZIP code. This must be a physical address. Post office boxes are not acceptable.

**FL 10** Patient’s Birth date (*MM-DD-YYYY*). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.

**FL 11** Patient’s Sex. This item is used in conjunction with FLs 66-69 (*diagnoses*) and FL 74 a-e (*surgical procedures*) to identify inconsistencies.

**FL 12** Admission Date

**FL 13** Admission Hour

**FL 14** Type of Admission. This code indicates priority of the admission.

**FL 15** Source of Admission. This code indicates the source of admission or outpatient registration.

**FL 16** Discharge Hour

**FL 17** Patient Status. This code indicates the patient’s status as of the “Through” date of the billing period (*FL 6*).

**FLs 18-28** Condition Codes

**FL 29** Accident State

**FL 30** Not Required

**FLs 31-34** Occurrence Codes and Dates

**FLs 35-36** Occurrence Span Code and Dates

**FL 37** Not Required

**FL 38** Responsible Party Name and Address

**FLs 39-41** Value Codes and Amounts

**FL 42** Revenue Code

**FL 43** Revenue Description—A narrative description or standard abbreviation for each revenue code in FL 42. Descriptions or abbreviations correspond to the revenue codes.

**FL 44** HCPCS/Rates. When coding HCPCS, enter the HCPCS code describing the procedure. May be required for correct reimbursement.

**FL 45** Service Date. If submitting claims for outpatient services, report a separate date for each day of service.

**FL 46** Service Units. The entries in this column quantify services by revenue category (*e.g., number of days, a particular type of accommodation, pints of blood*). Up to seven digits may be entered.

**FL 47** Total Charges

**FL 48** Non-covered Charges. The total non-covered charges pertaining to the related revenue code in FL 42 is entered here.

**FL 49** Not Required

**FL 50A-C** Payer Identification. Enter the primary payer on line A.

**FL 51A-C** Health Plan Identification Number

**FL 52A-C** Release of Information. A “Y” code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An “R” code indicates the release is limited or restricted. An “N” code indicates no release on file.

**FL 53A-C** Assignment of Benefits Certification Indicator

**FL 54A-C** Prior Payments. For all services other than inpatient hospital and Skilled Nursing Facility (SNF) services, the sum of any amount(s) collected by the provider from the patient toward deductibles and/or co-insurance are entered on the patient (last) line of this column.

**FL 55A-C** Not Required

**FL 56** National Provider Identifier (NPI). Beginning May 23, 2008, NPI number is required.

**FL 57A-C** Other Provider Identifier Number

**FL 58A-C** Insured’s Name

**FL 59A-C** Patient’s Relationship to Insured
FL 60A-C  Certificate/Social Security Number/Health Insurance Claim/Identification Number
FL 61A-C  Group Name. Indicate the name of the insurance group or plan.
FL 62A-C  Insurance Group Number
FL 63A-C  Treatment Authorization Code. Contractor-specific or HHA PPS OASIS code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient preadmission or preprocedure, the authorization number is required for all approved admissions or services.
FL 64A-C  Document Control Number (DCN). Original DCN number of the claim to be adjusted.
FL 65A-C  Employer Name. Name of the employer that provides health care coverage for the individual identified on FL 58.
FL 66  Diagnosis and Procedure Code Qualifier (ICD Version Indicator)
FL 67  Principal Diagnosis Code. HCFA only accepts ICD-9-CM diagnostic and procedural codes which use definitions contained in Department of Health and Human Services (DHHS) Publication Number (PHS) 89-1260 or HCFA-approved errata supplements to this publication. Diagnosis codes must be full ICD-9-CM diagnosis codes, including all five digits where applicable.
FL 67A-Q  Other Diagnosis Codes
FL 68  Not Required
FL 69  Admitting Diagnosis. For inpatient hospital claims subject to Peer Review Organization (PRO) review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient’s hospital admission.
FL 70a-c  Patient’s Reason for Visit
FL 71  Prospective Payment System (PPS) Code
FL 72a-c  External Cause of Injury (ECI) Code
FL 73  Not Required
FL 74  Principal Procedure Code and Date. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.
FL 74a-e  Other Procedure Codes and Dates. The full ICD-9-CM, Volume 3, Procedure Codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL 74). The date of each procedure is shown in the date portion of Item 74, as applicable (MM-DD-YY).
FL 75  Not Required
FL 76  Attending/Referring Physician ID
FL 77  Operating Physician Name and Identifiers
FL 78-79  Other Physician ID
FL 80  Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Authorized signature of non-network providers.
FL 81a-d  Code Field

**Condition Codes**

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<td>Condition is employment related</td>
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<tr>
<td>03</td>
<td>Patient covered by insurance not reflected here</td>
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<tr>
<td>06</td>
<td>ESRD patient in first 30 months of entitlement covered by employer group health insurance</td>
</tr>
<tr>
<td>08</td>
<td>Beneficiary would not provide information concerning other insurance coverage</td>
</tr>
<tr>
<td>18</td>
<td>Maiden name retained</td>
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<tr>
<td>19</td>
<td>Child retains mother’s name</td>
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<tr>
<td>31</td>
<td>Patient is student (full-time—day)</td>
</tr>
<tr>
<td>33</td>
<td>Patient is student (full-time—night)</td>
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<tr>
<td>34</td>
<td>Patient is student (part-time)</td>
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<tr>
<td>36</td>
<td>General Care Patient in a special unit</td>
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<tr>
<td>38</td>
<td>Semi-private room not available</td>
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<td>39</td>
<td>Private room medically necessary</td>
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<td>40</td>
<td>Same-day transfer</td>
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<td>41</td>
<td>Partial hospitalization</td>
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<td>46</td>
<td>Nonavailability statement on file</td>
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<td>48</td>
<td>Psychiatric residential treatment centers for children and adolescents</td>
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<td>55</td>
<td>Skilled Nursing Facility (SNF) bed not available</td>
</tr>
<tr>
<td>56</td>
<td>Medical appropriateness</td>
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<tr>
<td>60</td>
<td>Day outlier</td>
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<tr>
<td>61</td>
<td>Cost outlier</td>
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</table>
Beneficiary elects not to use lifetime reserve days

A0 TRICARE External Partnership Program
A2 Physically Handicapped Children’s Program
C1 Approved as billed
C2 Automatic approval as billed based on focused review
C3 Partial approval
C4 Admission/services denied
C5 Postpayment review applicable
C6 Admission pre-authorization
C7 Extended authorization
G0 Distinct medical visit (OPPS)

**Value Codes and Amounts**

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<td>01</td>
<td>Most common semi-private rate</td>
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<tr>
<td>02</td>
<td>Hospital has no semi-private rooms</td>
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<tr>
<td>05</td>
<td>Professional component included in charges and also billed separate to carrier</td>
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<tr>
<td>30</td>
<td>Preadmission testing</td>
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<td>31</td>
<td>Patient liability amount</td>
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<td>37</td>
<td>Pints of blood furnished</td>
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<tr>
<td>46</td>
<td>Number of grace days</td>
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**Occurrence Span Codes**

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<td>01</td>
<td>Auto accident</td>
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<tr>
<td>02</td>
<td>No fault insurance involved—including auto accident/other</td>
</tr>
<tr>
<td>03</td>
<td>Accident/tort liability</td>
</tr>
<tr>
<td>04</td>
<td>Accident/employment related</td>
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<tr>
<td>05</td>
<td>Accident/No medical or liability coverage</td>
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<td>06</td>
<td>Crime victim</td>
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<td>21</td>
<td>Date UR notice received</td>
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<td>22</td>
<td>Date active care ended</td>
</tr>
<tr>
<td>24</td>
<td>Date insurance denied</td>
</tr>
<tr>
<td>25</td>
<td>Date benefits terminated by primary payer</td>
</tr>
<tr>
<td>26</td>
<td>Date Skilled Nursing Facility bed became available</td>
</tr>
<tr>
<td>27</td>
<td>Date of hospice certification or re-certification</td>
</tr>
<tr>
<td>28</td>
<td>Date comprehensive outpatient rehabilitation plan established or last reviewed</td>
</tr>
<tr>
<td>29</td>
<td>Date outpatient physical therapy plan established or last reviewed</td>
</tr>
<tr>
<td>30</td>
<td>Date outpatient speech pathology plan established or last reviewed</td>
</tr>
<tr>
<td>31</td>
<td>Date beneficiary notified of intent to bill (accommodations)</td>
</tr>
<tr>
<td>32</td>
<td>Date beneficiary notified of intent to bill (procedures or treatments)</td>
</tr>
<tr>
<td>33</td>
<td>First day of the Medicare Coordination Period for End-Stage Renal Disease (ESRD) beneficiaries covered by Employer Group Health Plan (EGHP)</td>
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## List of Tables

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<tr>
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An Important Note about TRICARE Program Information

This TRICARE Provider Handbook will assist you in delivering TRICARE benefits and services. At the time of printing, the information in this handbook is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulation. Changes to TRICARE programs are continually made as public law and/or federal regulation are amended. For the most recent information, contact Health Net Federal Services, LLC, at 1-877-TRICARE (1-877-874-2273) or visit www.healthnetfederalservices.com. More information regarding TRICARE can also be found online at www.tricare.mil. Contracted TRICARE providers are obligated to abide by the rules, procedures, policies, and program requirements as specified in this TRICARE Provider Handbook, which is a summary of the TRICARE regulations and manual requirements related to the program. TRICARE regulations are available on the TRICARE Management Activity Web site at www.tricare.mil.