Your guide to TRICARE programs, policies and procedures
**TRICARE North Region Provider Handbook Updates**

**Update #1: Effective: June 23, 2011**

Insert On Page 88, Participation On Claims

**Participation On Claims**

With respect to the submission of a claim by a physician or supplier or their representative, the provider certifies that the services shown on the claim are medically indicated and necessary for the health of the patient and were personally furnished by the physician/supplier or furnished incident to his/her professional service by his/her employee under his/her immediate personal supervision, except as otherwise permitted by Medicare or TRICARE regulations.

For services to be considered as “incident” to a physician’s professional service:
- They must be rendered under the physician’s immediate personal supervision by his/her employee;
- They must be an integral, although incidental part of a covered physician’s service;
- They must be of kinds commonly furnished in physician’s offices; and
- The services of non-physicians must be included on the physician’s bills.

A non-institutional network provider/supplier, further certifies that he/she (or any employee) who rendered services is not an active duty member of the Uniformed Services or a civilian employee of the U.S. Government (refer to 5 United States Code (USC) 5536). Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal law.

**Update #2: Effective: July 1, 2011**

On Page 81, Health Net Conditions of Participation for Network Providers

Delete existing note and add new note under General Conditions:

**Delete:** Note: This requirement may be waived for pediatric-and obstetric-only providers in accordance with the applicable TRICARE-issued Medicare Waiver.

**Add:** Note: This requirement may be met either with a signed participation agreement with Medicare or participating with Medicare on a claim-by-claim basis.
An Important Note about TRICARE Program Information

This *TRICARE North Region Provider Handbook* will assist you in delivering TRICARE benefits and services. At the time of publication, April 1, 2011—March 31, 2012, the information in this handbook is current. It is important to remember that TRICARE policies and benefits are governed by public law, federal regulation and the Government’s amendments to Health Net Federal Services’ (Health Net) managed care support (MCS) contract. Changes to TRICARE programs are continually made as public law, federal regulation and Health Net’s MCS contract are amended. For up-to-date information visit [www.hnfs.com](http://www.hnfs.com) or contact Health Net at **877-TRICARE (877-874-2273)**.

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

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Photos courtesy of Shutterstock.com
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Using This TRICARE North Region Provider Handbook

This TRICARE North Region 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. TRICARE program changes and updates may be communicated periodically through the TRICARE Provider News publications. The TRICARE North Region Provider Handbook is updated annually. You may request a hardcopy version of this handbook through the Health Net Federal Services, LLC website at www.hnfs.com or by calling 877-TRICARE (877-874-2273).

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

Give Us Your Opinion

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

If you have any recommended feedback on this handbook contact Health Net at 877-TRICARE (877-874-2273).
Welcome to TRICARE and the North Region

What Is TRICARE?

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

TRICARE brings together military and civilian health care professionals and resources to provide high-quality health care services. TRICARE is managed in three stateside regions—TRICARE North, TRICARE South, and TRICARE West. In these U.S. regions, TRICARE is jointly managed by the TRICARE Management Activity (TMA) and TRICARE Regional Offices. TMA has partnered with civilian regional contractors in the North, South, and West regions to assist TRICARE regional directors and military treatment facility (MTF) commanders in operating an integrated health care delivery system.

Your Regional Contractor

As the managed care support contractor (MCSC), Health Net Federal Services, LLC (Health Net) administers the TRICARE program in the North Region, which 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 Iowa (Rock Island Arsenal area), Missouri (St. Louis area) and Tennessee (Ft. Campbell area only).

Health Net is committed to preserving the integrity, flexibility, and durability of the Military Health System by offering beneficiaries access to the finest health care services available, thereby contributing to combat readiness.

Health Net TRICARE Contract Administration

Health Net develops and maintains TRICARE contract administration. Health Net uses various partnerships for certain services:

- **Health Net**: Develops and maintains the medical or surgical network
- **MHN, Inc.**: Develops and maintains the behavioral health network
- **PGBA, LLC (PGBA)**: Provides and maintains claims processing and claims customer service activities

TRICARE Regions

<table>
<thead>
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<th>Region</th>
<th>Contact Information</th>
</tr>
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<tr>
<td>North Region</td>
<td>Health Net Federal Services, LLC 877-TRICARE (877-874-2273) <a href="http://www.hnfs.com">www.hnfs.com</a></td>
</tr>
<tr>
<td>South Region</td>
<td>Humana Military Healthcare Services, Inc. 800-444-5445 <a href="http://www.humana-military.com">www.humana-military.com</a></td>
</tr>
<tr>
<td>West Region</td>
<td>TriWest Healthcare Alliance Corp. 888-TRIWEST (888-874-9378) <a href="http://www.triwest.com/provider">www.triwest.com/provider</a></td>
</tr>
</tbody>
</table>
Provider Resources

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

Health Net Federal Services
Website: www.hnfs.com

The Health Net Federal Services website at www.hnfs.com, along with the PGBA-maintained www.myTRICARE.com website, provides information about TRICARE benefits, processes, requirements, and operations in the North Region, as well as access to business tools. Patient responsibility, referral and authorization requirements, preventive care, frequently asked questions, and timely news and program updates are available on these sites.

Visit the Provider section of the Health Net website to:

- View the TRICARE North Region Provider Handbook and TRICARE Provider News
- Download forms
- Read important updates about the TRICARE program and Health Net processes
- Access information about claims and reimbursement

Providers can register to use the secure provider portal, which allows them to:

- Verify a patient’s TRICARE eligibility, other health insurance status, and deductible and catastrophic cap expenses
- Use the Prior Authorization, Referral and Benefit Tool to learn about prior authorization and referral requirements as well as benefit coverage
- Primary care manager (PCM) enrollee roster—provides a list of beneficiaries enrolled to a PCM
- Submit and check the status of referral and prior authorization requests
- Use XPressClaim® to submit and check the status of claims
- Create DataMart reports to view patient claims history, set up electronic funds transfer and view remits
- Access TRICARE provider materials and forms and send secure e-mails

Electronic Funds Transfer

You can sign up for electronic funds transfer (EFT) at www.myTRICARE.com. Registering for EFT requires having signature authority. This means you are authorized to disburse funds, sign checks, add, modify or terminate bank account information.

Visit www.myTRICARE.com, and select “Provider,” then click on the North Region. This will take you to the North Region Provider welcome page. Select the “Electronic Claims Filing” tab, then “Electronic Funds Transfer (EFT)” and follow the steps to sign-up.

Electronic Claims

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

The following are some of the many benefits of filing claims electronically:

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

Providers registered on the PGBA website at www.myTRICARE.com can file claims through XPressClaim. XPressClaim allows providers to submit CMS-1500 and UB-04 claims and receive instant payment results. You can also print a patient summary receipt while your patient is still in the office. There is no cost to use XPressClaim.

Register at www.myTRICARE.com to begin using XPressClaim.
Online Provider Directory

The online provider directory makes it easy to locate other TRICARE providers. The directory is located on the provider section of the Health Net website at www.hnfs.com. The directory provides various information, including the following:

- Location
- Beneficiary category
- Provider name
- Provider type
- Provider specialty
- Gender
- Accepting new patients status
- Office phone number
- Office fax number
- Additional language(s)

Keep your demographic information up to date to ensure that Health Net provides accurate information to TRICARE beneficiaries and other providers. Network providers are strongly encouraged to visit the online Provider directory to confirm that their individual listings are accurate. If you are a network provider and you are not listed in the Provider directory and you wish to be listed, please contact the Health Net Customer Service Line at 877-TRICARE (877-874-2273) to inquire about being listed. To update your information go to the Provider directory section of the Health Net website, locate your name and update your information.

Most, but not all, network providers are listed in the directory. Emergency room physicians, urgent care physicians and other hospital-based providers may not be listed. Non-network providers are not listed in the directory. Information in the Provider directory is subject to change without notice. Before choosing a network provider, beneficiaries are encouraged to call and confirm the provider is accepting new TRICARE patients.

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

Providers can call Health Net’s toll-free customer service line, 877-TRICARE (877-874-2273), Monday through Friday, 7:00 a.m. to 7:00 p.m. Eastern Time, for general assistance with TRICARE benefits, claims and requirements. Additionally, this Health Net customer service line also offers an interactive voice response (IVR) system to allow beneficiaries and providers to access many self-service features 24 hours a day, seven days a week. Follow the simple prompts to get quick information, verify beneficiary eligibility, check claims status and review authorization request.

TRICARE Provider News

TRICARE produces the bi-monthly TRICARE Provider News for network providers. TRICARE Provider News includes articles about important TRICARE benefits and updates, tips for submitting referral and authorization requests, filing claims and other topics. To view new and archived issues, visit the provider section of the Health Net website at www.hnfs.com.
TRICARE Service Centers

TRICARE Service Centers (TSCs), located throughout the TRICARE North Region, are staffed by customer service representatives who assist both beneficiaries and providers. MTF providers and TSC staff work together to deliver health care services and perform administrative actions. To locate a TSC, visit www.hnfs.com.

TRICARE North Region Provider Handbook and TRICARE Manuals


Other Provider Resources

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

Provider Resources

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<th>Contact Information</th>
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</thead>
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<td>Allowable charges</td>
<td>View and download TRICARE-allowable charge schedules</td>
<td><a href="http://www.tricare.mil/cmac">www.tricare.mil/cmac</a></td>
</tr>
<tr>
<td>Behavioral Health Care Provider Locator and Appointment Assistance Line</td>
<td>Locate behavioral health care providers and schedule urgent and routine behavioral health care appointments. This line is not for crisis intervention.</td>
<td>Health Net Federal Services, LLC 877-747-9579</td>
</tr>
<tr>
<td>Benefits and patient responsibility</td>
<td>TRICARE benefits and patient financial responsibility in the North Region</td>
<td><a href="http://www.hnfs.com">www.hnfs.com</a> 877-TRICARE (877-874-2273)</td>
</tr>
<tr>
<td>Claims</td>
<td>Claims processing</td>
<td>877-TRICARE (877-874-2273) 877-334-2524 (electronic data interchange claims) <a href="http://www.myTRICARE.com">www.myTRICARE.com</a></td>
</tr>
<tr>
<td>Eligibility</td>
<td>Verify TRICARE patient eligibility through (automated system)</td>
<td><a href="http://www.hnfs.com">www.hnfs.com</a> 877-TRICARE (877-874-2273) <a href="http://www.myTRICARE.com">www.myTRICARE.com</a></td>
</tr>
</tbody>
</table>
### Provider Resources continued

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<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Contact Information</th>
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<tr>
<td>Fraud and abuse</td>
<td>Anonymously report suspected fraud or abuse to Health Net</td>
<td>800-977-6761</td>
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| ICD-9 Diagnosis Coding Manual and Healthcare Common Procedure Coding System Manual | Request copies or obtain assistance                                          | Ingenix  
2525 Lake Park Boulevard  
P.O. Box 27116  
Salt Lake City, UT 84127-0116  
800-INGENIX (800-464-3649), option 1  
[www.shopingenix.com](http://www.shopingenix.com) |
| Military Medical Support Office (MMSO)        | MMSO supports remotely located Active Duty, Reservist, and National Guard service members in the Army, Navy, Marine Corps, Air Force, and Coast Guard who must receive health care through civilian health care systems. MMSO also provides support to other service member populations such as new acquisitions en route to their first permanent duty station. MMSO functions include, but are not limited to, authorization of specialty medical care, dental care, and claim payment determinations. | Military Medical Support Office  
P.O. Box 886999  
Great Lakes, IL 60088-6999  
888-MHS-MMSO (888-647-6676)  
[www.tricare.mil/MMSO](http://www.tricare.mil/MMSO) |
| Pharmacy services                             | Pharmacy services, claims, prior authorization, and other services and requirements | [Express Scripts, Inc.](http://www.express-scripts.com)  
P.O. Box 52150  
Phoenix, AZ 85072  
877-363-1303  
Fax: 877-895-1900  
[www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE) |
| Prior authorization and referral requests      | Request prior authorizations and referrals from Health Net                    | Use the Online Authorization and Referral Submission Tool to request prior authorizations and referrals:  
[www.hnfs.com](http://www.hnfs.com)  
For medically urgent requests:  
877-TRICARE (877-874-2273)  
Outpatient:  
888-299-4181 (fax)  
Inpatient:  
877-809-8667 (fax) |
| Prior authorization and referral requirements  | Determine if prior authorization or referrals from Health Net are required    | Use the Prior Authorization, Referral and Benefit Tool:  
[www.hnfs.com](http://www.hnfs.com)  
877-TRICARE (877-874-2273) |
Healthy People 2020: Expand Your Perspective

What is Healthy People 2020?

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

Healthy People serves a variety of purposes, ranging from providing information on current health status or public health priority setting, to offering a comprehensive compilation of statistical information on health promotion and disease prevention. Healthy People is designed to serve as a road map for improving the health of all people in the United States and is a valuable resource in determining how you can participate most effectively in improving the nation's health.

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

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Figure 1.1

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Prior authorization and referral status check</td>
<td>Check request status</td>
<td>Use the Online Referrals and Authorizations Status Tool: <a href="http://www.hnfs.com">www.hnfs.com</a> 877-TRICARE (877-874-2273)</td>
</tr>
<tr>
<td>Provider certification status and demographic and Tax Identification Number (TIN) updates</td>
<td>Check network and non-network provider contracting and certification status, demographics, and TINs</td>
<td>877-TRICARE (877-874-2273)</td>
</tr>
<tr>
<td>TRICARE For Life (TFL)</td>
<td>For assistance with TFL benefits, claims, and requirements</td>
<td>WPS/TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889 (general correspondence only, no claims) 866-773-0404 866-773-0405 (TDD) <a href="http://www.TRICARE4u.com">www.TRICARE4u.com</a></td>
</tr>
</tbody>
</table>
Healthy People 2020 Strives to:

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

Goals of Healthy People 2020

Healthy People 2020 builds on 2010 goals, and proposes four main goals that apply to all of its objectives:

- Achieve health equity, eliminate disparities and improve health for all groups
- Eliminate preventable disease, disability, injury and premature death
- Create social and physical environments that promote good health for all
- Promote healthy development and healthy behaviors across every stage of life

What Can You Do?

- Understand the role that prevention, health promotion and community-based health programs have on the determinants of health
- Integrate Healthy People initiatives into current programs, special events, publications and meetings
- Utilize national health observances (e.g., Great American Smokeout or American Heart Month) that align with leading health indicators
- Monitor community-based and community-determined wellbeing initiatives to improve “community capacity” and 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 resources, use and refer to them to assist you in developing and implementing programs and interventions for your patients

To stay up to date with the progress of Healthy People 2020 Leading Health Indicators, Goals and Objectives, visit www.healthypeople.gov/hp2020
Healthy People Resources

Healthy People website:  
www.healthypeople.gov

For printed manuals and other resources, call  
800-367-4725

Office of Disease Prevention and Health Promotion website:  
www.odphp.osophs.dhhs.gov/

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

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National Disaster Medical System (NDMS)

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

Your hospital may also qualify to become a Federal Coordinating Center and may participate in exercise development and emergency plans.

You are encouraged to become a member of NDMS. Learn more about this invaluable service by visiting the NDMS website at http://www.phe.gov/Preparedness/responders/ndms/Pages/default.aspx.

To learn more about the requirements for you or your hospital to become part of a Disaster Medical Assistance Team or to register go to: http://www.phe.gov/esarvhp/Pages/default.aspx.
Important Provider Information

TRICARE providers must abide by the rules, procedures, policies and program requirements specified in this TRICARE North Region Provider Handbook, which summarizes TRICARE regulations and requirements related to the program. For more information, visit www.hnfs.com or call Health Net Federal Services, LLC (Health Net) at 877-TRICARE (877-874-2273).

TRICARE Policy Resources

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

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


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 care plans, clearinghouses and providers who electronically conduct certain financial and administrative transactions must comply with HIPAA. TRICARE health plans, military treatment facilities (MTFs), providers, contractors, subcontractors, clearinghouses and other business associates all fall within these categories.

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

HIPAA Transactions and Code Sets


Figure 2.1 of this section lists mandated HIPAA electronic transactions.
### HIPAA Electronic Transactions

**Figure 2.1**

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

### HIPAA Privacy Rule

As required by the HIPAA Privacy Rule, provider offices and groups must train all workforce members, as necessary to carry out their functions, on policies and procedures related to protected health information (PHI). PHI is the information created and obtained as providers deliver services to beneficiaries. PHI is any information about health status, provision of health care or payment for health care that can be linked to a specific individual. PHI is defined as information that contains any of the following data about individuals:

- 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)

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

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

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

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

Refer to “Release of Patient Information” later in this section for more information.
**Military Health System Notice of Privacy Practices**

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

Privacy officers are located at every MTF. They serve as beneficiary advocates for privacy issues and respond to beneficiary inquiries about PHI and privacy rights. More information about privacy practices and other HIPAA requirements is available at [www.tricare.mil/hipaa](http://www.tricare.mil/hipaa). Beneficiaries and providers may also e-mail inquiries to privacymail@tma.osd.mil.

**HIPAA Employer Identifier**

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

**HIPAA National Provider Identifier**

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

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

TRICARE providers should already have NPIs. If you do not have an NPI, complete the online NPPES application at [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do) or download a paper application of the National Provider Identifier (NPI) Application/Update Form at [www.cms.hhs.gov/cmsforms/downloads/cms10114.pdf](http://www.cms.hhs.gov/cmsforms/downloads/cms10114.pdf). You can also request an application from the NPI Enumerator in one of the following ways:

<table>
<thead>
<tr>
<th>Phone</th>
<th>800-465-3203 800-692-2326 (TTY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-mail</td>
<td><a href="mailto:customerservice@npienumerator.com">customerservice@npienumerator.com</a></td>
</tr>
<tr>
<td>Mail</td>
<td>NPI Enumerator</td>
</tr>
<tr>
<td></td>
<td>PO Box 6059</td>
</tr>
<tr>
<td></td>
<td>Fargo, ND 58108-6059</td>
</tr>
</tbody>
</table>

Providers registered at [www.myTRICARE.com](http://www.myTRICARE.com) can submit NPIs to Health Net online by logging onto [www.hnfs.com](http://www.hnfs.com) or [www.myTRICARE.com](http://www.myTRICARE.com). If you do not have Internet access, fax your NPI information to 888-244-4025. Call the toll-free Electronic Data Interchange Help Desk at 877-EDI-CLAIM (877-334-2524) if you need assistance.

TRICARE Provider Types

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

Note: Federal government employees—including active duty service members (ADSMs)—who are health care providers are generally not TRICARE-authorized to provide care in civilian facilities. TRICARE only reimburses TRICARE-authorized network providers.

Figure 2.2 provides an overview of various TRICARE provider types.

TRICARE Provider Types

<table>
<thead>
<tr>
<th>TRICARE-Authorized Providers</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• TRICARE-authorized providers meet TRICARE licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (laboratories and radiology providers) and pharmacies. TRICARE-authorized providers do not include pharmacists, dietitians, naturopaths, chiropractors, kinesthesiologists, massage therapists, genetic counselors or any other provider type not specifically named in TRICARE Policy Manual, Chapter 11. Please refer to TRICARE Policy Manual, Chapter 11, to review TRICARE-authorized provider requirements. Beneficiaries are responsible for the full cost of care if they see providers who are not TRICARE-authorized.</td>
<td>• Non-network providers do not have signed agreements with Health Net and are, therefore, considered “out of network.” In most cases, beneficiaries must have approval from Health Net to seek care from non-network providers.</td>
</tr>
<tr>
<td>• There are two types of TRICARE-authorized providers: Network and Non-Network.</td>
<td>• There are two types of non-network providers: Participating and Nonparticipating.</td>
</tr>
</tbody>
</table>

Network Providers¹ | Non-Network Providers²

• Regional contractors (i.e., Health Net) have established networks, even in areas far from military treatment facilities
• TRICARE network providers:
  • Have signed agreements with Health Net and/or MHN to provide care
  • Agree to file claims and handle other paperwork for TRICARE beneficiaries

¹ Network providers must have malpractice insurance.

Participating

• May choose to participate on a claim-by-claim basis
• Agree to file claims for TRICARE beneficiaries, accept payment directly from TRICARE, and accept the TRICARE-allowable charge as payment in full for their services

Nonparticipating

• Do not agree to accept the TRICARE-allowable charge or file claims for TRICARE beneficiaries
• Have the legal right to charge beneficiaries up to 15% above the TRICARE-allowable charge for services

¹ To become a network provider, visit www.hnfs.com or call Health Net at 877-TRICARE (877-874-2273).

Reminder:

• Please note that TRICARE network providers under an Agreement with Health Net shall not receive or accept, for any reason, reimbursement in excess of the TRICARE-allowable charge.

• If as a TRICARE network provider, you are an individual, home health care, freestanding laboratory or free-standing radiology provider who accepts Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) or Department of Veterans Affairs (VA) patients then you are required to serve as a participating provider and to accept assignment with the VA.
When Accepting Patients from the Department of Veterans Affairs

The VA and CHAMPVA are not TRICARE programs. They are unique health care benefit programs administered by the VA.

**VA Patients**

VA patients are veterans with service-connected disabilities.

Health Net reports network providers to the VA as TRICARE network providers. Non-institutional network providers are asked to accept requests from the VA to provide care to veterans. The VA has the right to directly contact providers and request that they provide care to VA patients on a case-by-case basis. If you agree to see a VA patient, the referral and instructions for seeking reimbursement from the Veterans Affairs Medical Center (VAMC) will be provided by the patient at the time of the appointment.

Health Net requires network providers (individual, home health care, free-standing laboratories and free-standing radiology only) who accept VA patients to serve as participating providers and accept assignment with the VA. If seen by the TRICARE network provider, any documentation of and reimbursement for the care rendered to the VA patient is a matter between the referring VAMC and the provider.

All TRICARE network providers are listed in the provider directory as willing to receive VA queries on availability. If you choose not to accept VA inquiries please contact Health Net at 877-TRICARE (877-874-2273) to update your status.

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

**CHAMPVA Patients**

CHAMPVA is a health care benefit that provides coverage to the spouse or widow(er) and to the children of eligible veterans.

Health Net also reports network providers to CHAMPVA as TRICARE network providers. Health Net requires network providers (individual, home health care, free-standing laboratories and free-standing radiology only) who accept CHAMPVA patients to serve as a participating provider and accept assignment with the VA.

All TRICARE network providers are listed in the provider directory as accepting CHAMPVA patients and accepting assignments on claims. If you choose not to accept CHAMPVA patients please contact Health Net at 877-TRICARE (877-874-2273) to update your status.

Instructions on how to submit CHAMPVA claims (CHAMPVA Fact Sheet 01-16) are available on the Health Net website at www.hnfs.com. Also see the Claims Processing and Billing Information section of this handbook for more information about submitting CHAMPVA claims.

**Military Treatment Facilities**

A military treatment facility (MTF) is a military hospital or clinic usually located on or near a military installation. The civilian TRICARE provider network supplements MTF resources and may work closely with the MTF to ensure that patients get the care they need. To locate an MTF, visit www.hnfs.com.

**Military Treatment Facility Right of First Refusal**

An MTF has the “right of first refusal” (ROFR) for TRICARE Prime referrals for inpatient admissions, specialty appointments, and procedures requiring prior authorization, provided the MTF is able to deliver the service requested by the patient’s network provider. This means TRICARE Prime beneficiaries must first try to obtain care at the MTF. MTF staff members review referrals to determine if they can provide care within access standards. If the service is not available within access standards, the MTF refers the beneficiary to a TRICARE network provider.

**Note:** The ROFR process does not apply to Active Duty Service Members or Active Duty Family Members enrolled in TRICARE Prime Remote seeking care at an MTF.
TRICARE Mail Order Pharmacy

TRICARE offers a mail order prescription plan managed by Express Scripts®. Prescriptions by mail order are the least expensive option for TRICARE beneficiaries when they are not using an MTF pharmacy. Home delivery is best suited for medication taken on a regular basis. You may prescribe up to a 90-day supply of medications. New prescriptions can be faxed (with a fax cover sheet) directly to Express Scripts at 877-895-1900. Faxed prescriptions must contain the following information in order to be processed: patient’s full name, date of birth, address and sponsor’s Social Security number. Only prescriptions faxed directly from a provider’s office will be accepted and prescriptions for Schedule II controlled substances cannot be faxed (they must be mailed).

Visit www.express-scripts.com/TRICARE or call Express Scripts at 877-363-1303 for more information.

Urgent Care

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

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

If you are not available to provide a same-day appointment, you may refer the beneficiary to an urgent care center.

Emergency Care

TRICARE defines an emergency as a medical, maternity or psychiatric condition that would lead a “prudent layperson” (someone with an average knowledge of health and medicine) to believe that a serious medical condition exists. This includes situations when the absence of immediate medical attention would result in a threat to life, limb or sight; when a person has severe, painful symptoms that require immediate attention to relieve suffering; or when a person is an immediate risk to self or others.

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

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

Corporate Services Provider Class

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

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

Network corporate services providers are certified during the credentialing process. Non-network corporate services providers must apply to become TRICARE-authorized. Qualified non-network providers can download the Application for TRICARE Provider Status/Corporate Services Provider at www.myTRICARE.com or call Health Net at 877-TRICARE (877-874-2273) for assistance.

Note: The claim form must identify the provider who actually renders care.
Corporate services providers who deliver home health care are exempt from prospective payment system billing rules. For more information about corporate services provider coverage and reimbursement, refer to the TRICARE Policy Manual, Chapter 11, Section 12.1, at http://manuals.tricare.osd.mil.

Managing the Network

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

Provider Certification and Credentialing

TRICARE Certification

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

Certified providers are considered non-network TRICARE-authorized providers unless they choose to join the TRICARE network. Non-network providers may also choose to “accept assignment” (i.e., participate) on a case-by-case basis. If a non-network provider accepts assignment, he or she is considered a participating non-network provider and agrees to accept the TRICARE-allowable charge as payment in full for covered services and file claims for TRICARE beneficiaries. Nonparticipating, non-network providers do not have to accept the TRICARE-allowable charge or file claims for beneficiaries.

In many cases, providers can see TRICARE patients and file claims with TRICARE to initiate the certification process. However, behavioral health care providers, certain non-Medicare-certified providers, skilled nursing facilities and others must submit certification forms to PGBA, LLC prior to providing health care services. To download certification forms, visit www.myTRICARE.com, go to the Provider website, choose North Region, and click on the forms tab.

Note: Providers who are not eligible for TRICARE authorization are financially responsible for any care provided to TRICARE beneficiaries. Contact Health Net to verify eligibility before delivering care.

Additionally, freestanding partial hospitalization programs (PHPs), residential treatment centers (RTCs) and substance use disorder rehabilitation facilities (SUDRFs) must first be certified by Keystone Peer Review Organization, Inc (KêPRO™), the TRICARE Quality Monitoring Contractor. Providers should contact KêPRO to speak with a TRICARE certification representative and request information. For more information regarding KêPRO, log on to www.kepro.org. Once KêPRO certifies the facility, the provider must complete the MHN contracting process. Call MHN at 800-541-3353 for more information.

Note: Acute care hospital-based PHPs must be certified by The Joint Commission. However, freestanding PHPs must be certified and enter into a participation agreement with TRICARE and obtain the required authorization prior to admitting patients. Freestanding PHPs that are interested in becoming TRICARE-authorized should contact KêPRO at www.kepro.org, effective April 1, 2011. A TRICARE-authorized chemical dependency PHP for inpatient services does not need to be certified by KêPRO.

TRICARE Credentialing

To join the TRICARE network, a TRICARE-authorized provider must complete the credentialing process and sign a contract with Health Net. The credentialing process requires verification of the provider’s education, board certification, license, professional background, malpractice history and other pertinent data. A fully executed copy of the contract will be forwarded to the provider. Health Net monitors each network provider’s quality of care and adherence to DoD, TRICARE and Health Net policies. Network providers must be contracted re-credentialed every three years.
Note: Behavioral health care providers—including freestanding PHPs, RTCs and SUDRFs—must be credentialed by MHN. For more information, call MHN at 800-541-3353.

For more information about TRICARE certification and credentialing, visit www.hnfs.com and see the Health Care Administration section of this handbook.

Network Provider Responsibilities

Network providers sign contracts with Health Net and/or MHN to comply with all TRICARE and Health Net regulations. This handbook is not all-inclusive and only provides an overview of TRICARE policies and procedures. For more information about provider responsibilities and contract requirements, visit www.hnfs.com or call Health Net at 877-TRICARE (877-874-2273).

Non-Discrimination Policy

All TRICARE-authorized providers agree not to discriminate against any TRICARE beneficiary on the basis of his or her participation in TRICARE, source of payment, sex, age, race, color, religion, national origin, health status or disability. To access the full TRICARE policy, refer to the TRICARE Operations Manual, Chapter 1, Section 5, at http://manuals.tricare.osd.mil.

Office and Appointment Access Standards

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

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

- Initial behavioral health care appointment with a behavioral health care provider:
  - Urgent behavioral health care appointment: 24 hours
  - Routine behavioral health care appointment: One week (seven days)

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

Cancelled or Missed Appointments

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

Primary Care Manager’s Role

A primary care manager (PCM) is a military or network civilian provider assigned or selected to deliver non-emergency care to TRICARE Prime beneficiaries. Depending on state regulations and other factors, PCMs may be internal medicine physicians, family practitioners, pediatricians, general practitioners, obstetricians/gynecologists, physician assistants or nurse practitioners.

Each TRICARE Prime beneficiary selects or is assigned a PCM when he or she enrolls. Whenever possible, an MTF PCM is assigned. Otherwise, a TRICARE network PCM is assigned.
A TRICARE Prime beneficiary requires a referral and/or prior authorization to seek care from any provider besides his or her PCM, except in the following circumstances:

- When using the point of service (POS) option, which allows a TRICARE Prime beneficiary to receive non-emergency care without a referral from his or her PCM. However, when using this option, the beneficiary must pay a higher cost-share and a deductible.
- In an emergency
- If seeking clinical preventive services from a network provider
- For the first eight outpatient behavioral health care visits to a network provider per fiscal year (FY) (October 1–September 30)

**Note:** ADSMs need referrals and/or prior authorization for all non-emergency civilian care, including all behavioral health care services. ADSMs with network PCMs must follow all specialty referral and authorization guidelines.

Network PCMs sign contractual agreements with Health Net to follow TRICARE procedures and requirements for specialty care referrals and prior authorizations for non-emergency inpatient and certain outpatient services. Claims submitted for services rendered without required prior authorizations are subject to a 10 percent penalty of the TRICARE-allowable charge.

The PCM’s responsibilities to TRICARE Prime beneficiaries include:

- Performing primary care services and managing all care
- Rendering care for acute illness, minor accidents, and follow-up care for ongoing medical problems as authorized in the TRICARE Prime benefits plan
- Ensuring access to the necessary health care services, as well as any specialty requirements, if they cannot provide services themselves
- Providing access to care 24 hours a day, seven days a week, including after hours and urgent care or arranging for on-call coverage by another provider
- **Note:** The on-call provider must notify the PCM within 24 hours of an inpatient admission to ensure continuity of care.

- Determining the level of care needed:
  - Routine care—instructing the patient to contact the PCM’s office on the next business day to schedule an appointment
  - Urgent care—coordinating timely care for the patient
  - Referring patients for specialty care and obtaining referrals, when required, from Health Net
  - Obtaining prior authorization, when required, from Health Net

**Note:** It is the provider’s responsibility to verify demographic information, panel status, and ability to meet appointment and access standards. Notify Health Net in writing 10 days in advance if your demographic information changes, if you are no longer accepting new patients, or if you must close the enrollment panel for any period of time. You may fax information to 888-244-4025.

### Specialty Care Responsibilities

TRICARE Prime beneficiaries require a referral from their PCM for specialty care and may also require a referral from Health Net. The PCM and/or specialty care provider should coordinate with Health Net to obtain referrals and prior authorizations. A network provider who submits a claim for an unauthorized service is subject to a 10 percent penalty of the TRICARE-allowable charge.

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

#### TRICARE Prime:

- Active duty service member: PCM and/or Health Net referrals are required for all civilian specialty care. Additionally, prior authorization from Health Net is required for certain services.
- Active duty family members: PCMs should refer patients to MTFs or network providers whenever possible. ADFMs must obtain a PCM and/or Health Net referral for any care they receive from providers other than their PCMs or an On-Call physician acting on behalf of their PCM. This excludes preventive care services from network providers, the first eight outpatient behavioral health care visits per FY to network providers, or when using the POS option. Additionally, prior authorization from Health Net is required for certain services.
TRICARE Standard:

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

Note: Providers should use the Online Authorization and Referral Submission Tool on the Health Net website at www.hnfs.com to request prior authorizations. Online requests are preferred; however, Health Net will accept requests via fax (888-299-4181) if the provider is unable to submit electronically.

Clearly Legible Reports

Network providers must provide clearly legible reports (CLRs), which include consultation reports, operative reports and discharge summaries to the MTF within seven business days of care delivery. Behavioral health care network providers must submit brief initial assessments within seven business days. Network providers must follow the instructions included with the referral and/or authorization from Health Net. For additional information about CLRs, visit www.hnfs.com.

Note: The requirement to submit Clearly Legible Reports (CLRs) to the MTF is important and assists the MTF in meeting The Joint Commission requirements. Upon receipt of an approved referral or authorization from Health Net, providers will receive a letter that contains the secure fax number for coordinating the CLR with the MTF.

Health Net reminds network providers to fax all CLRs directly to the secure fax line for the requesting MTF. Our CLR Fax Matrix listed on www.hnfs.com includes the confidential MTF fax number for you to use. This CLR Fax Matrix also lists contact information should you have any CLR questions.

Note: The CLR secure fax number is different from the fax number used to submit TRICARE Service Request/Notification forms for referral and authorization requests.

For care referred by a non-MTF (civilian) provider, reports should not be sent to the local secure fax line. Follow your normal office protocol and forward non-MTF referred consultation reports to the requesting network provider within the seven (7) business day standard.

Urgent and Emergency Care CLR Responsibilities

In urgent and emergency situations, a preliminary report of a specialty consultation should be provided to the referring provider or MTF by telephone or using a secure fax line within 24 hours of the urgent/emergent care (unless best medical practices dictate less time is required for a preliminary report). Telephonic preliminary reports should be followed up with a CLR sent to the local secure MTF fax, including non-MTF referrals, within seven (7) business days of the urgent/emergent care. MTF individual fax numbers for urgent/emergent care can be found at www.hnfs.com.

Emergency Care Responsibilities

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

Health Net reviews admission information and authorizes continued care, if necessary. If TRICARE Prime beneficiaries seek unnecessary emergency care without required referral and/or authorization, they are responsible for paying Point of Service (POS) fees. Refer to the Medical Coverage section of this handbook for more information on emergency and urgent care services.
**Balance Billing**

A TRICARE network or participating non-network provider agrees to accept the TRICARE-allowable charge as payment in full for a covered service. These providers may not bill TRICARE beneficiaries more than this amount for covered services. Non-network, nonparticipating providers do not have to accept the TRICARE-allowable charge and may bill patients no more than 15 percent above the TRICARE-allowable charge. If the billed amount is less than the TRICARE-allowable charge, TRICARE reimburses the billed amount.

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

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

For more information about balance billing, visit www.hnfs.com or call Health Net at 877-TRICARE (877-874-2273).

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

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

Network providers must use the Request for Non-Covered Services form or equivalent (such as a statement or letter, written, dated and signed by the beneficiary prior to receipt of the services) to satisfy these requirements. A general agreement to pay, such as one signed by the beneficiary at the time of admission, is not sufficient to prove that a beneficiary was properly informed or agreed to pay. Notes demonstrating that the beneficiary has been fully informed in advance of receiving the services, that the services are excluded or excludable and that the beneficiary has agreed to pay for them must be documented in writing in the patient’s file. If the beneficiary does not sign a Request for Non-Covered Services form or equivalent, the provider is financially responsible for the cost of non-covered services he or she delivers. To download the Request for Non-Covered Services form, go to www.hnfs.com. Network providers should keep copies of the Request for Non-Covered Services form in their offices.

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

**Hold Harmless Policy for Network Providers**

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

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

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

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

For more information, visit www.hnfs.com or call Health Net at 877-TRICARE (877-874-2273).

Release of Patient Information

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

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

Even in those exceptional circumstances, the Privacy Act of 1974 prohibits disclosing sensitive information that could adversely affect the beneficiary. Providers must not disclose information about services with the following diagnostic codes to parents or guardians of any beneficiaries, including minors and mentally or physically disabled beneficiaries:

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

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

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

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

Release of Medical Records

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

- Calls on behalf of a spouse or adult child, age 18 or older (age 21 or older in Pennsylvania)
• Is the guardian (other than mother or father) of a minor dependent
• Is the spouse of a deployed ADSM
• Is divorced from the child’s TRICARE sponsor
• Was never married to his or her child’s TRICARE sponsor
• Has a different last name than the eligible children and/or multiple spouses are listed on the account. In the majority of cases, these would be the eligible stepchildren of the sponsor.
• Is the spouse or family member of a deceased sponsor

If you have additional questions about the HIPAA Privacy Rule and TRICARE, call Health Net at 877-TRICARE (877-874-2273) or visit www.tricare.mil/tmaprivacy or www.hhs.gov/ocr/hipaa.

Dismissing Patients

In rare circumstances, you may have a need to dismiss a TRICARE patient from your care. However, suddenly refusing to see a patient again, even one with whom the physician has had serious problems in the past, can be seen as patient abandonment and could lead to legal liability. TRICARE policy does not detail when it is appropriate to dismiss a patient. However, you must provide written notification of the dismissal to the TRICARE beneficiary, and you must offer 30 days of transitional care and/or referrals for urgent needs from the date of the dismissal letter. A copy of the written notice should be kept on file in the event of any confusion concerning the dismissal. Every practice should have a policy in place regarding how and when a patient should be discharged from care.

Updating Provider Information

The Health Net website includes a provider directory to help beneficiaries and other providers find local TRICARE network providers. Keeping your information up to date ensures that Health Net sends payments to your correct address and that TRICARE beneficiaries and other providers have your current contact information.

Network providers must visit the provider directory to confirm that their individual listings are accurate. Visit www.hnfs.com to update your listing. Should you discover that your name/practice is missing from the online directory, please call 877-TRICARE (877-874-2273).

The Health Net provider directory does not include non-network providers. However, non-network providers are encouraged to verify or update contact information, or fax updated information to 888-250-4355 or 888-279-3540.

Beneficiary Rights and Responsibilities

TRICARE Beneficiaries Have the Right to:

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

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

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

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

Respect and nondiscrimination—Beneficiaries have the right to receive considerate, respectful care from all members of the health care system without discrimination based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.
Confidentiality of health information—Beneficiaries have the right to communicate with health care providers in confidence and to have the confidentiality of their health care information protected as required by law. They also have the right to review, copy and request amendments to their medical records.

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

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

TRICARE Beneficiaries Have the Responsibility to:

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

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

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

TRICARE beneficiaries also have the responsibility to:

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

ADFMs enrolled in TRICARE Prime or TRICARE Prime Remote for Active Duty Family Members (TPRADFMs) do not have copayments, cost-shares or deductibles, except for:

• Pharmacy copayments
• POS cost-shares and deductibles
• TRICARE Extended Care Health Option cost-shares

TRICARE beneficiaries cannot be billed for the following charges:

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

An Important Message from TRICARE

Inpatient facilities are required to provide each TRICARE beneficiary with a copy of the document, An Important Message from TRICARE. This document details the beneficiary’s rights and obligations upon admission to the hospital. The signed document must be kept in the beneficiary’s file. A new document must be provided for each admission. Visit www.hnfs.com and search for a copy of An Important Message from TRICARE.
TRICARE Eligibility

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

All beneficiaries must register in the Defense Enrollment Eligibility Reporting System (DEERS) to be eligible for TRICARE. Beneficiaries can verify their eligibility in DEERS by calling 800-538-9552. However, providers must check beneficiary eligibility online through the Health Net Federal Services, LLC (Health Net) website at www.hnfs.com or by calling Health Net’s interactive voice response (IVR) system at 877-TRICARE (877-874-2273).

Verifying Eligibility

Providers must verify TRICARE eligibility at the time of service. Several identification (ID) and enrollment cards can be used to verify a patient’s eligibility for TRICARE. Providers should ensure beneficiaries have valid Common Access Cards (CACs), uniformed services ID cards, or eligibility authorization letters. Check the expiration dates on CACs and ID cards, and make copies of both sides of the cards for your files. See Copying ID Cards later in this section for additional information.

Note: The TRICARE Prime, TRICARE Prime Remote, TRICARE Reserve Select and TRICARE Retired Reserve enrollment cards are not required to obtain care but contain important information for beneficiaries.

Note: A CAC or ID card alone does not prove TRICARE eligibility. Providers must verify the card bearer’s TRICARE eligibility by logging into Health Net’s website at www.hnfs.com or by calling Health Net’s interactive voice response (IVR) system at 877-TRICARE (877-874-2273). Use the sponsor’s Social Security number (SSN) to verify eligibility. If you are verifying online, retain a printout of the eligibility verification screen for your files.

Common Access Card

Active duty service members and drilling National Guard and Reserve members carry common access cards (CACs). Before providing care, check the CAC expiration date. Although CACs are valid uniformed services ID cards, they do not, on their own, prove TRICARE eligibility. Providers must verify patient eligibility as described earlier in this section.

Uniformed Services Identification Card

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

The beneficiary category determines the ID card’s color as noted below:

- **Active duty service members**—CAC or DD Form 2ACT (green)
- **Active duty family members**—Uniformed Services Identification and Privilege Card—DD Form 1173 (tan)
- **National Guard and Reserve family members**—Department of Defense Guard and Reserve Family Member Identification Card—DD Form 1173-1, 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 (red)
- **Retirees**—United States Uniformed Services Identification Card (Retired)—DD Form 2 [RET] (blue)
- **Retiree family members**—DD Form 1173 (tan)
- **Transitional Assistance Management Program (TAMP) beneficiaries**—Department of Defense/Uniformed Services Identification and Privilege Card—DD Form 2765 (tan)
ID cards include the following information:

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

Note: A beneficiary’s valid photo ID presented with a copy of the sponsor’s activation orders *(when activated for more than 30 consecutive days)* may serve as proof of the patient’s TRICARE eligibility. Because beneficiaries under age 10 are usually not issued ID cards, the parent’s proof of eligibility may serve as proof of eligibility for the child. Providers must verify TRICARE eligibility by logging into Health Net’s website at [www.hnfs.com](http://www.hnfs.com) or by calling Health Net’s interactive voice response (IVR) system at 877-TRICARE (877-874-2273).

Newborns are covered under their Sponsor’s ID card, however, they must be registered in DEERS. If the Prime option is desired, the newborn must be enrolled in Prime.

**Social Security Number Reduction Plan**

In response to the growing need to protect beneficiaries’ personal identification information, the DoD is removing SSNs from DoD ID cards. Although SSNs are being removed from ID cards, TRICARE continues to base all operations *(e.g., eligibility verification, claims submission, appeals)* on the sponsor’s SSN. Providers should continue to copy DoD ID cards for their records and must ensure that they have the sponsor’s SSN for each TRICARE patient.

The SSN removal has three phases:

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

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

All eligible family members and survivors age 75 or older are issued permanent ID cards. These ID cards should read “INDEF” in the box titled “Expiration Date.”

**Copying Identification Cards**

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

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

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

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

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

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

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

TRICARE and Medicare Eligibility

TRICARE beneficiaries who are eligible for premium-free Medicare Part A and Part B to remain TRICARE-eligible. These beneficiaries are automatically covered under TRICARE For Life (TFL), TRICARE’s Medicare wraparound coverage, when their Medicare Part A and Part B coverage is effective.

The following beneficiaries may delay Medicare Part B enrollment and keep their TRICARE benefits, regardless of premium-free Medicare Part A eligibility:

- Active duty family members remain eligible for TRICARE Prime and TRICARE Standard even if they do not have Medicare Part B. However, once sponsors retire from active duty, all sponsors and family members eligible for premium-free Medicare Part A must also have Medicare Part B to keep their TRICARE benefits.
- TRICARE Reserve Select and US Family Health Plan (USFHP) beneficiaries are not required to have Medicare Part B to remain covered under these programs.

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

For more information about TFL, see “TRICARE For Life” later in this chapter.

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 the VA, he or she has the option to use either TRICARE or their VA benefits. Furthermore, TRICARE allows such beneficiaries to receive medically necessary care for the same episode of care, even if they have already been treated at the VA. However, TRICARE will not duplicate payments made by or authorized to be made by the VA for treatment of a service-connected disability.

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

TRICARE Program Options

TRICARE offers comprehensive medical and dental benefits to all TRICARE beneficiaries. It is important to be aware of the choices available according to beneficiary category.

TRICARE Prime Coverage Options

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

When activated for more than 30 consecutive days, National Guard and Reserve members are covered as ADSMs and must enroll in TRICARE Prime or TPR. During activation, their eligible family members are covered as ADFMs and may enroll in TRICARE Prime or TPRADF or may use TRICARE Standard and TRICARE Extra.
TRICARE Prime beneficiaries receive TRICARE Prime enrollment cards, and both TPR and TPRADFM beneficiaries receive TPR enrollment cards. These cards include important contact information but are not required to obtain care. Although beneficiaries should expect to present their cards at the time of service, enrollment cards do not verify TRICARE eligibility.

TRICARE Prime

TRICARE Prime is a managed care option available in TRICARE Prime Service Areas (PSAs). ADSMs who live and work in PSAs must enroll in TRICARE Prime; however, ADFMs and other eligible beneficiaries may enroll in TRICARE Prime or use TRICARE Standard and TRICARE Extra. Each TRICARE Prime beneficiary is assigned or may select a primary care manager (PCM). Whenever possible, a PCM located at an MTF is assigned, but a TRICARE network civilian PCM may be assigned if an MTF PCM is not available.

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

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

TPR and TPRADFM provide TRICARE Prime coverage for ADSMs and family members who live with them in remote locations through a network of civilian TRICARE-authorized providers, institutions and suppliers (network or non-network). ADSMs and their families who live and work more than 50 miles or a one-hour drive time from the nearest MTF designated as adequate to provide primary care may be eligible to enroll in TPR or TPRADFM. Each TPR or TPRADFM beneficiary is assigned or may select a PCM. Whenever possible, a TRICARE network civilian PCM is assigned, but a non-network PCM may be assigned if a network provider is not available.

TPR and TPRADFM beneficiaries should always seek non-emergency care from their PCMs, unless they are using the POS option. In most cases, a TPR or TPRADFM beneficiary must obtain a referral to receive non-emergency care from another provider.

TPR ADSMs do not need referrals, prior authorizations or fitness-for-duty review to receive primary care. Specialty and inpatient services require referrals and prior authorizations from Health Net and the Military Medical Support Office (MMSO) service point of contact (SPOC). The SPOC determines referral management for fitness-for-duty care.

To determine if a particular ZIP code falls within a TPR coverage area, use the ZIP code lookup tool at www.tricare.mil/tpr/default_zip.aspx.

Primary Care Managers

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

PCMs can be MTF or civilian TRICARE-authorized network or non-network providers. The following provider types may serve as TRICARE PCMs:

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

See the Important Provider Information section of this handbook for more information about PCM roles and responsibilities.
TRICARE Prime Point of Service Option

- Point of service (POS) is an option that allows TRICARE Prime and TPRADFM beneficiaries to obtain medically necessary TRICARE-covered services from any TRICARE-authorized provider (network or non-network), other than their PCM, without first obtaining a referral.
- The POS cost-share is applied when:
  - A TRICARE Prime or TPRADFM beneficiary receives care from a network or non-network TRICARE-authorized provider without a referral from his or her PCM.
  - A TPRADFM beneficiary self-refers to a non-network TRICARE-authorized provider without a referral from Health Net.
  - A TRICARE Prime/TPRADFM beneficiary self-refers to a network specialty care provider after a referral has been authorized by Health Net to a MTF specialty care provider.
  - An MTF-enrolled TRICARE Prime beneficiary self-refers to a network or non-network network provider for primary care (routine) or urgent care services.

The POS option does not apply in the following circumstances:

- Emergency department services
- Preventive care services from a network provider
- The initial eight behavioral health outpatient visits from a network provider*  
- Primary other health insurance (OHI) care
- TRICARE Prime/TPRADFM newborn or adoptee care (a newborn or adoptee is covered as a TRICARE Prime/TPRADFM beneficiary for the first 60 days after birth or adoption as long as one additional family member is enrolled in TRICARE Prime/TPRADFM).
- Active duty service member care
- TRICARE Standard beneficiary care

When using the POS option, beneficiaries must pay a deductible and 50 percent of the TRICARE-allowable charge. POS costs do not apply to the catastrophic cap, and special considerations apply for beneficiaries with OHI. The POS option does not affect provider reimbursement, and the beneficiary pays a larger portion of the total TRICARE-allowable charge. It is important to be aware of referral end dates and to advise beneficiaries when additional referrals are required. For more information visit www.hnfs.com or call Health Net at 877-TRICARE (877-874-2273).

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

* The POS option applies to all non-emergency behavioral health care from non-network providers and to outpatient behavioral health visits to network providers beyond the eighth visit per FY. Prior authorization requirements still apply.

TRICARE Standard and TRICARE Extra

TRICARE Standard and TRICARE Extra are available to all TRICARE-eligible beneficiaries except ADSMs. Beneficiaries are responsible for annual deductibles and cost-shares. TRICARE Standard and TRICARE Extra beneficiaries do not have PCMs, and they may self-refer to any TRICARE-authorized provider. However, certain services (e.g., inpatient admissions for substance use disorders and behavioral health, adjunctive dental care, home health services) require prior authorization from Health Net. See the Health Care Management and Administration section of this handbook for more information about prior authorization requirements.

TRICARE Standard is a fee-for-service option that allows beneficiaries to seek care from any TRICARE-authorized non-network provider. TRICARE Extra, which is a preferred provider option, allows beneficiaries to reduce out-of-pocket costs by visiting TRICARE network providers. For cost information, call Health Net at 877-TRICARE (877-874-2273) or visit www.tricare.mil/costs.
TRICARE For Life

TRICARE for Life (TFL) benefit medical claims are processed by the national TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC) Wisconsin Physicians Service Insurance Corporation (WPS).

TRICARE For Life is Medicare-wraparound coverage for “dual-eligible” TRICARE beneficiaries. Regardless of age, beneficiaries are considered dual-eligible if they are entitled to premium-free Medicare Part A and eligible for TRICARE because they also have Medicare Part B coverage. TRICARE for Life provides comprehensive health care coverage. Beneficiaries have the freedom to seek care from any Medicare-certified providers, at MTFs on a space-available basis or at VA facilities (if eligible). Medicare-participating providers file claims with Medicare first. After paying its portion, Medicare automatically forwards the claim to TFL for processing (unless the beneficiary has OHI). TFL pays after Medicare for covered health care services.

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

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

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

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

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

How TRICARE For Life Works

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

If you have questions regarding how TRICARE will pay after Medicare, or to obtain prior authorization requirements, contact the TRICARE For Life contractor, WPS, at 866-773-0404. If you have questions regarding Medicare benefits and coverage, contact Medicare at 800-MEDICARE (800-633-4227). See the Health Care Management and Administration section of this handbook for more information about TRICARE referral and authorization requirements.

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

• For services covered by both TRICARE and Medicare, Medicare pays first and TRICARE pays its share of the remaining expenses second (unless the beneficiary has OHI).

• For services covered by TRICARE but not by Medicare, TRICARE processes the claim as the primary payer. The beneficiary is responsible for the applicable TFL deductible and cost-share.
For services covered by Medicare but not by TRICARE, Medicare is the primary payer and TRICARE pays nothing. The beneficiary is responsible for the applicable Medicare deductible and cost-share.

For services not covered by Medicare or TRICARE, the beneficiary is responsible for the entire bill.

See the Claims Processing and Billing Information section of this handbook for information about TFL claims and coordinating with OHI. For more information about TFL, call WPS/TFL, at 866-773-0404 or visit the WPS/TFL website at www.TRICARE4u.com.

TRICARE Pharmacy Program

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

TRICARE beneficiaries have the following options for filling prescriptions:

- MTF pharmacies—Using an MTF pharmacy is the least expensive option, but formularies may vary by MTF pharmacy location. Contact the local MTF pharmacy to check availability before prescribing a medication.

- TRICARE Mail Order Pharmacy—The mail order pharmacy is the preferred method when not using an MTF pharmacy.

- TRICARE retail network pharmacies—Beneficiaries can access a network of approximately 60,000 retail pharmacies in the United States and certain U.S. territories (Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands).

- Non-network retail pharmacies—Filling prescriptions at a non-network retail pharmacy is the most expensive option and is not recommended to beneficiaries.

For more information about benefits and costs, visit www.tricare.mil/pharmacy or www.express-scripts.com/TRICARE or call Express Scripts at 877-363-1303.

Member Choice Center

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

To learn more about the Member Choice Center, call Express Scripts at 877-363-1303 or access information online by visiting www.tricare.mil/pharmacy or www.express-scripts.com/TRICARE.

Quantity Limits

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

Prior Authorizations

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

Visit www.tricareformularysearch.org for a general list of TRICARE-covered prescription drugs that require prior authorization. Providers can also locate prior authorization and medical necessity criteria forms for retail network and mail order prescriptions. MTF pharmacies may follow different procedures. At the top of each form, there is information on where to send the completed form. For assistance, call 877-363-1303 or the Pharmacy Prior Authorization line at 866-684-4488.
Generic Drug Use Policy

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

If a generic-equivalent drug does not exist, the brand-name drug is dispensed at the brand-name cost.

Uniform Formulary Drugs and Non-Formulary Drugs

In 2005, the DoD established a uniform formulary, which is a list of covered generic and brand-name drugs. The formulary also contains a third tier of medications that are designated as “non-formulary.” The DoD Pharmacy and Therapeutics (P&T) Committee may recommend to the Director of the TRICARE Management Activity that certain drugs be placed in the third, “non-formulary” tier. These medications include any drug in a therapeutic class determined to be not as clinically effective or as cost-effective as other drugs in the same class.

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

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

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

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

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

Step Therapy

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

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

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

For a complete list of medications subject to step therapy, see Medications Identified by the DoD P&T Committee at www.tricare.mil/pharmacy/prior_auth.cfm.
Medicare-Eligible Beneficiaries

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

You may direct eligible beneficiaries who inquire about Medicare Part D coverage to visit the TRICARE website 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 800-MEDICARE (800-633-4227) or visit the Medicare website at www.medicare.gov.

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

Pharmacy Data Transaction Service

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

Specialty Medication Care Management

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

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

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

Beneficiaries enrolled in the Specialty Medication Care Management program may contact pharmacists 24 hours a day, seven days a week. The specialty clinical team reaches out to the beneficiaries’ physicians, as needed, to address beneficiary issues, such as side effects or disease exacerbations. If any of your patients currently fill specialty medication prescriptions at retail pharmacies, the specialty clinical team will provide brochures detailing the program as well as pre-populated enrollment forms.

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

Note: Some specialty medications may not be available through mail order because the manufacturer limits the drug’s distribution to specific pharmacies. If you submit a prescription for a limited-distribution medication, Express Scripts either forwards the prescription to a pharmacy of the patient’s choice that can fill it or provides the patient with instructions about where to send the prescription. To determine if a specialty medication is available through mail order visit www.tricareformularysearch.org.
TRICARE Dental Options

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

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

TRICARE Active Duty Dental Program

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

TRICARE Dental Program

The TDP, administered by United Concordia, is a voluntary dental insurance program available to eligible ADFMs and National Guard and Reserve and Individual Ready Reserve members and their eligible family members. Active duty service members (and National Guard and Reserve members called to active duty for a period of more than 30 consecutive days or eligible for the pre-activation benefit up to 90 days prior to their report date) are not eligible for the TDP. They receive dental care at military DTFs or through the ADDP.

For more information about the TDP, visit the TDP website at www.TRICAREdentalprogram.com or call United Concordia toll-free at 800-866-8499.

TRICARE Retiree Dental Program

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

For more information about the TRDP, visit the TRDP website at www.trdp.org or call Delta Dental toll-free at 888-838-8737.

TRICARE for the National Guard and Reserve

The seven National Guard and Reserve components include:

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

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

A line-of-duty (LOD) condition is determined by the military service and includes any injury, illness or disease incurred or aggravated while the National Guard or Reserve member is in a duty status, either inactive duty (such as reserve drill) or active duty status. This includes the time period when the member is traveling directly to or from the location where he or she performs military duty. The National Guard and Reserve member’s service determines eligibility for LOD care, and the member receives a written authorization that specifies the LOD condition and terms of coverage.

Note: The DEERS does not show eligibility for LOD care.
Line-of-duty coverage is separate from any other TRICARE coverage in effect, such as:

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

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

Health Net forwards any claim that was not referred by an MTF or pre-approved by MMSO to MMSO for approval or denial. The provider should submit medical claims directly to Health Net unless otherwise specified on the LOD-written authorization or requested by the National Guard or Reserve member’s Medical Department Representative. When submitting claims for a National Guard or Reserve member with an LOD condition, the service(s) listed on the claim must be directly related to the condition documented on the LOD-written authorization.

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

Coverage When Activated for More than 30 Consecutive Days

When called to active duty for more than 30 consecutive days, National Guard and Reserve members are TRICARE-eligible. They are considered ADSMs and must enroll in TRICARE Prime or TPR, depending on location, when they reach their final duty stations.

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

TRICARE Reserve Select

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

After purchasing either member-only or member-and-family TRS coverage, TRS members receive TRS enrollment cards. These cards include important contact information but are not required to obtain care. Although beneficiaries should expect to present their cards at the time of service, enrollment cards do not verify TRICARE eligibility. You should make a photocopy of the front and back of the card for your files. Visit www.hnfs.com or call Health Net’s toll-free TRS customer service number at 800-555-2605 to verify coverage status.

TRICARE Retired Reserve

TRICARE Retired Reserve (TRR) is a premium-based health plan offered by the DoD that members of the Retired Reserve may qualify to purchase. TRR provides comprehensive health care coverage and patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra, but TRR beneficiaries must pay monthly premiums. TRR members may self-refer to any TRICARE-authorized provider; however, certain services (e.g., inpatient admissions for substance use disorders and behavioral health, adjunctive dental care, home health services) require prior authorization from Health Net. See the Health Care Management and Administration section of this handbook for more information about authorization requirements.
After purchasing either member-only or member-and-family TRR coverage, TRR members will receive TRR enrollment cards. These cards include important contact information but are not required to obtain care. Although beneficiaries should expect to present their cards at the time of service, enrollment cards do not verify TRICARE eligibility. You should make a photocopy of the front and back of the card for your files. Call Health Net’s toll-free customer service number 877-TRICARE (877-874-2273), to verify coverage status.

Cancer Clinical Trials

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

There are three types of NCI clinical trials:

- **Phase I trials**—TRICARE does not cover Phase I trials, which are primarily concerned with assessing a drug’s safety, due to its highly experimental nature.

- **Phase II trials**—TRICARE beneficiaries may participate in NCI-sponsored 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 NCI-sponsored Phase III trials, which compare a promising new treatment against the standard approach. These studies also focus on a particular type of cancer.

**Trial Costs**

TRICARE cost-shares all medical care and testing required to determine eligibility for an NCI-sponsored trial. All medical care required to participate in a trial is processed under normal reimbursement rules (subject to the TRICARE 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 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

**Trial Participation**

Participation in NCI clinical trials requires prior authorization. Call the TRICARE North Region Cancer Clinical Trials Coordinator at 800-395-7821 from 8 a.m. to 5 p.m. You must contact the coordinator before beginning the evaluation or any treatment under the clinical trial. The NCI website at www.cancer.gov lists some, but not all, of the Phase II and Phase III NCI-sponsored clinical trials. To determine if clinical trials are available, call the TRICARE North Region Cancer Clinical Trials Coordinator.

**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 those offered by the basic TRICARE programs (e.g., TRICARE Prime, TPRADFM, TRICARE Standard or TRICARE Extra). Potential ECHO beneficiaries must be ADFMs, have qualifying conditions and be registered to receive ECHO benefits.

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

- Moderate or severe mental retardation
- Serious physical disability
- Extraordinary physical or psychological condition of such complexity that the beneficiary is homebound
• Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler (under age 3) that is expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability

• Multiple disabilities, which may qualify if there are two or more disabilities affecting separate body systems

**Note:** Active duty sponsors with family members seeking ECHO registration must enroll in their service’s Exceptional Family Member Program (EFMP)—unless waived in specific situations—and register to be eligible for ECHO benefits. There is no retroactive registration for the ECHO program. Visit [www.militaryhomefront.dod.mil/efm](http://www.militaryhomefront.dod.mil/efm) for more information about EFMP.

**ECHO Provider Responsibilities**

TRICARE providers, especially PCMs, are responsible for managing care for TRICARE beneficiaries. Any TRICARE provider (PCM or specialist) can inform the patient’s sponsor about the ECHO benefit. Refer patients to Health Net’s website at [www.hnfs.com](http://www.hnfs.com) for information about eligibility and ECHO registration. Providers must obtain prior authorization for all ECHO services, and they may be requested to provide medical records, such as progress notes, or assist beneficiaries with completing EFMP documents. Network and participating non-network providers must submit ECHO claims to PGBA.

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

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

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

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

**ECHO Benefits**

ECHO provides coverage for the following products and services:

• ABA therapy *(which includes the DoD Enhanced Access to Autism Services Demonstration, discussed later in this section)* and other types of special education *(which may include ABA but excludes education the school system is responsible for)* that are not available through local community resources

• Assistive services (e.g., those from a qualified interpreter or translator)

• Durable equipment, including adaptation and maintenance

• Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)

• Rehabilitative services

• Respite care *(during any month when at least one other ECHO benefit is received and limited to the United States, Guam, Puerto Rico and the U.S. Virgin Islands)*
  - ECHO respite care—Up to 16 hours of care
  - EHHC respite care—Up to eight hours per day, five days per week

• Training to use special education and assistive technology devices

• Institutional care when a residential environment is required

• Transportation under certain limited circumstances (i.e., to and from institutions or facilities to receive otherwise-allowable ECHO benefits)

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

**Note:** All ECHO services require prior authorization from Health Net.
**ECHO Costs**

The government’s limit for the cost of certain ECHO services combined (excluding EHHC) is $36,000 per beneficiary, per FY. This limit only applies to:

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

The government’s limit for the cost of all other ECHO services combined (excluding EHHC) is $2,500 per beneficiary, per month. Costs for these benefits also count toward the limit of $36,000 per beneficiary, per FY.

Beneficiaries are responsible for ECHO cost-shares in addition to cost-shares for basic TRICARE benefits (e.g., under TRICARE Prime, TPRADFM, TRICARE Standard and TRICARE Extra). ECHO cost-shares do not count toward the catastrophic cap. EHHC costs do not count toward ECHO monthly or yearly maximum cost-shares.

For more information about TRICARE ECHO, visit [www.hnfs.com](http://www.hnfs.com); refer to the TRICARE Policy Manual, Chapter 9, at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil); visit [www.tricare.mil/echo](http://www.tricare.mil/echo); or call Health Net at 877-TRICARE (877-874-2273).

**DoD Enhanced Access to Autism Services Demonstration**

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

This demonstration provides information that will enable the DoD to determine the following:

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

The Enhanced Access to Autism Services Demonstration allows non-certified paraprofessional providers or tutors to provide autism services (in particular, ABA), under the supervision of TRICARE-authorized certified therapists, to ADFMs in the United States. The demonstration is effective for services provided on and between March 15, 2008, and March 14, 2012. Non-certified tutors may provide ABA services under close supervision. Authorized supervisors are required to direct and oversee tutors who provide services and must verify that tutors are trained and able to perform the services required to treat children with autism.

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

For more information about the Enhanced Access to Autism Services Demonstration, visit [www.hnfs.com](http://www.hnfs.com); refer to the TRICARE Operations Manual, Chapter 18, Section 9 at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil); or visit the Special Programs Web page at [www.tricare.mil](http://www.tricare.mil).

**Supplemental Health Care Program**

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. Although the DoD funds the SHCP, it is separate from TRICARE and follows different rules. Only the following individuals are eligible for the SHCP:

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

The SHCP covers care referred or authorized by the MTF and/or the MMSO. When SHCP beneficiaries need care, the MTF (if available) or the MMSO refers ADSMs and certain other patients to network providers as needed. If services are unavailable at the MTF, Referral For Civilian Medical Care (DD Form 2161) is sent to Health Net before the patient receives specialty care (form may vary by MTF site). Health Net and the MTF, as appropriate, identify a network provider and notify the patient. For non-MTF referred care, the SPOC determines if the ADSM receives care from an MTF or network provider.

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

### Transitional Health Care Benefits

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

#### Continued Health Care Benefit Program

The Continued Health Care Benefit Program (CHCBP) is a premium-based health care program administered by Humana Military Healthcare Services, Inc. (Humana Military). CHCBP offers temporary transitional health care coverage (18–36 months) after TRICARE eligibility ends.

CHCBP acts as a bridge between military health care benefits and the beneficiary’s new civilian health care plan. CHCBP benefits are comparable to TRICARE Standard, but differences do exist. The main difference is that beneficiaries must pay quarterly premiums. Additionally, under CHCBP, providers are not required to use or coordinate with MTFs, and MTF nonavailability statements are no longer required.

Providers must coordinate with Humana Military to obtain referrals and authorizations for CHCBP beneficiaries. Providers must seek authorization for care that is deemed medically necessary. Medical necessity rules for CHCBP beneficiaries follow TRICARE Standard guidelines. Call Humana Military at 800-444-5445 to coordinate CHCBP referrals and authorizations or fax information to 877-270-9113.

For more information about CHCBP, visit Humana Military’s website at www.humana-military.com or call 800-444-5445. Health Net cannot provide CHCBP assistance or information.
Transitional Assistance Management Program

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

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

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

For more information about TAMP, visit www.tricare.mil/tamp.

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

Transitional Care for Service-Related Conditions Program

The TCSRC program extends TRICARE coverage for qualified former active duty, National Guard and Reserve members who are diagnosed with service-related conditions during their 180-day TAMP period.

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

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

The TCSRC benefit covers care only for the specific service-related condition, and preventive and health maintenance care is not covered. TCSRC beneficiaries may seek care at MTFs or from TRICARE-authorized network providers if MTF care is not available. There are no copayments or cost-shares under TCSRC, and providers should submit claims to Health Net. The TCSRC benefit is available worldwide.

For more information on TCSRC, visit www.tricare.mil/tcsrc.
Medical Coverage

TRICARE only covers health care services and devices that are medically necessary and considered proven. Some types of care have limitations. Beneficiary liability for covered services varies according to program option (i.e., TRICARE Prime, TRICARE Prime Remote [TPR], TRICARE Prime Remote for Active Duty Family Members [TPRADFM], TRICARE Standard and TRICARE Extra, or TRICARE for Life). See the “TRICARE Program Options” in the TRICARE Eligibility section of this handbook for specific beneficiary liability information.

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

For additional information or specific questions about TRICARE-covered services, visit www.hnfs.com or contact Health Net Federal Services, LLC (Health Net) at 877-TRICARE (877-874-2273) 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 at www.hnfs.com for regular articles about benefits and program changes.

Some military treatment facilities (MTFs) may offer services or procedures that TRICARE does not cover. Beneficiaries should contact their local MTF for information about these services. Additionally, the Military Medical Support Office (MMSO) may authorize services for active duty service members that are not regular TRICARE benefits. Providers are reimbursed for these services only if they obtain prior authorization from Health Net for these services.

Network Utilization

TRICARE network or MTF providers should be the first option in TRICARE patient care. In most cases, patient care can be arranged swiftly through TRICARE’s vast provider network while meeting access to care standards, such as wait and drive time. Requests for specialty care referrals or outpatient treatment authorizations that are to non-network providers will be redirected to TRICARE network providers of the same specialty whenever possible.

Adjunctive Dental Care

The TRICARE medical benefit covers adjunctive dental care. Services are considered adjunctive dental care when the dental services are necessary to treat a covered medical (non-dental) condition. Prior authorization is required for all non-emergency adjunctive dental care to determine if the services can be covered under TRICARE. However, emergency adjunctive care (e.g., dental services required to treat facial injuries resulting from a car accident) does not require prior authorization. The following are common medical conditions that may require adjunctive dental care:

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

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

Facility services required to safeguard the life of the patient—Some patients have medical conditions that could become life-threatening during routine dental procedures (e.g., tooth extraction for a hemophiliac). TRICARE covers the facility services and supplies. Under this category, TRICARE does not cover the professional dental services or anesthesiology.
Children age five or younger or beneficiaries with severe disabilities—Children age five and under and beneficiaries with severe developmental, mental or physical disabilities may require facility and anesthesiology services to prevent trauma and/or injury during routine dental procedures. TRICARE covers the facility services and supplies and anesthesiology services. Under this category, TRICARE does not cover the professional dental services, and anesthesiology services rendered by the attending dentist are not covered. TRICARE will cover anesthesiology services rendered by a separate anesthesiology provider.

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

TRICARE does not cover routine, preventive, restorative, prosthodontic, periodontic or emergency dental care that is not related to a medical condition. The following are examples of services not covered:

- Care for accidental injury to the teeth alone
- Emergency care for dental conditions (e.g., dental pain)
- Implant, crown, denture and bridge provisions
- Teeth extractions, including impacted wisdom teeth
- Treatment of dental caries and periodontal disease

For more information regarding the adjunctive dental benefit, refer to the TRICARE Policy Manual, Chapter 8, Section 13.1, at http://manuals.tricare.osd.mil.

Ambulance Services

TRICARE covers the following ambulance services:

- Transfers between a beneficiary’s home, accident scene or other location and a hospital
- Transfers between hospitals
- Transfers from a hospital-based emergency room to a hospital more capable of providing the required care
- Transfers between a hospital or skilled nursing facility (SNF) and another hospital-based or freestanding therapeutic or diagnostic department/facility

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

TRICARE does not cover the following ambulance services:

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

Note: 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 not advisable.

For additional information about ambulance services, refer to the TRICARE Policy Manual, Chapter 8, Section 1.1, at http://manuals.tricare.osd.mil. For additional information about emergency services, refer to the TRICARE Policy Manual, Chapter 2, Section 4.1.

Clinical Preventive Services

Clinical preventive care is not diagnostic, but is intended to maintain and promote good health. Clinical preventive services are not related directly to specific illnesses, injuries, symptoms or obstetrical care; they are performed as periodic health screenings, health assessments or health maintenance visits. Services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic patients.
Coverage may vary according to beneficiary type, age and program option. TRICARE Prime beneficiaries do not need referrals or prior authorizations for clinical preventive services from MTF or network providers.* TRICARE Prime beneficiaries must have referrals and/or authorizations for non-network provider services. TRICARE Standard and TRICARE Extra beneficiaries may seek clinical preventive care from TRICARE-authorized network and non-network providers, and cost-shares and deductibles may apply.

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

* All ADSMs, except for TRICARE Prime Remote-enrolled ADSMs visiting their PCMs, must obtain referrals and prior authorizations to receive clinical preventive services.

Comprehensive Health Promotion and Disease Prevention Examinations

An annual comprehensive clinical preventive exam is covered if it includes an 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, Pap smear, mammogram, colon cancer screening or prostate cancer screening is required for claims payment. School enrollment physicals for children ages 5–11 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 receiving an 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. A TRICARE Prime beneficiary does not need a referral for a clinical preventive exam and accompanying covered immunization or screening if rendered by a network provider.

Targeted Health Promotion and Disease Prevention Services

Some covered screening examinations listed below may be performed in conjunction with a comprehensive clinical preventive exam if appropriate. The intent is to maximize preventive care.

Cancer Screenings

- Colonoscopy—TRICARE provides limited coverage for a routine colonoscopy. There are no cost-shares or copayments for colorectal cancer screenings, unless rendered for diagnosed medical conditions. The following coverage maximums apply:
  - Average risk—One every 10 years beginning at age 50.
  - Increased risk:
    - Due to hereditary non-polyposis colorectal cancer syndrome—Every two years beginning at age 25, or five years younger than earliest age of diagnosis in affected relative, whichever is earlier, and then annually after age 40
    - Due to familial risk of sporadic colorectal cancer—For first-degree relatives with sporadic colorectal cancer or adenoma before age 60, or with multiple first-degree relatives with colorectal cancer or adenomas, a colonoscopy should be performed every three to five years, beginning 10 years earlier than the youngest affected relative
  - Fecal occult blood testing—One per 12 month period, guaiac-based or immunochemical-based testing of three consecutive stool samples annually starting at age 50.
  - Mammograms—One per 12 month period beginning at age 40. For high-risk patients, one baseline mammogram at age 35 and annually thereafter.
  - Breast Magnetic Resonance Imaging (MRI) scan—One per 12 month period for asymptomatic patients (TRICARE Prime for patients age 30+ or TRICARE Standard patients age 35+) at high risk of developing breast cancer according to American Cancer Society® guidelines. These guidelines include women with a:
    - BRCA1 or BRCA2 gene mutation
    - First-degree relative (parent, child, or sibling) with a BRCA1 or BRCA2 gene mutation
    - Lifetime risk of approximately 20–25 percent or greater as defined by BRCAPRO or other models that are largely dependent on family history
    - History of chest radiation between ages 10–30
• History of Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with one of these syndromes

• **Physical exam for colorectal cancer**—A digital rectal examination should be included in periodic health exams of individuals age 40 and older.

• **Proctosigmoidoscopy or sigmoidoscopy**—Routine proctosigmoidoscopy, or sigmoidoscopy performed for colorectal cancer screening, in the absence of cancer or other presenting signs, is a limited benefit under TRICARE.

  • **Average risk**—One proctosigmoidoscopy or sigmoidoscopy every three years beginning at age 50.

• **Prostate cancer screening**—One per 12 month period, digital rectal exam and prostate-specific antigen screening for:
  
  • All men age 40 and older with a family history of prostate cancer in two or more other family members
  
  • All men age 45 and older with a family history of prostate cancer in at least one other family member
  
  • All African-American men age 45 or older, regardless of family history

  • All men age 50 and older

• **Routine Pap smears**—One per 12 month period or less often, at provider discretion (though not less than every three years), for women starting at age 18 (younger, if sexually active).

• **Skin cancer screening**—Exams are covered at any age for a beneficiary who is at high risk due to family history or increased sun exposure.

### Cardiovascular Disease Screening

A lipid panel cholesterol test is covered at least once every five years beginning at age 18. Blood pressure screening is covered annually for children (ages 3–6) and a minimum of every two years after age 6 (children and adults).

### Eye Examinations

Beneficiaries with medical conditions related to the eye may require non-routine eye exams as recommended by their health care provider. Prime enrolled beneficiaries may require a referral for non-routine eye exams. See the Health Care Management and Administration section of this handbook for referral details.

## TRICARE Vision Care Coverage for Beneficiaries Over Age 6

<table>
<thead>
<tr>
<th>Beneficiary</th>
<th>Coverage</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active duty service member (ADSM)—TRICARE Prime</td>
<td>As needed to maintain fitness for duty</td>
<td>Military treatment facility, unless specifically referred</td>
</tr>
<tr>
<td>ADSM—TRICARE Prime Remote</td>
<td>As needed to maintain fitness for duty</td>
<td>Network optometrist or ophthalmologist</td>
</tr>
<tr>
<td>Active duty family member—TRICARE Prime or TRICARE Reserve Select</td>
<td>One routine eye exam per calendar year</td>
<td>Network optometrist or ophthalmologist</td>
</tr>
<tr>
<td>Active duty family member—TRICARE Standard or TRICARE Reserve Select</td>
<td>One routine eye exam per calendar year</td>
<td>Any TRICARE-authorized optometrist or ophthalmologist</td>
</tr>
<tr>
<td>Retirees, their families and others—TRICARE Prime</td>
<td>One routine eye exam every 24 months</td>
<td>Network optometrist or ophthalmologist</td>
</tr>
<tr>
<td>Retirees, their families and others—TRICARE Standard</td>
<td>None</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

All TRICARE-eligible children ages 6 and younger receive vision coverage under the TRICARE well-child benefit. Figure 4.2 provides well-child vision coverage details.
**Note:** Routine eye exams for diabetic patients of any age are not limited and one eye exam per year is recommended. TRICARE Prime/TRICARE Prime Remote beneficiaries with diabetes do not require a referral or authorization when using a network optometrist or ophthalmologist.

For more information about TRICARE’s coverage for vision care and other clinical preventive services, refer to the TRICARE Policy Manual, Chapter 7, Sections 6.1–6.2, at http://manuals.tricare.osd.mil.

### Immunizations

Age-appropriate vaccines, including influenza vaccines, are covered as recommended by the Centers for Disease Control and Prevention (CDC). TRICARE coverage is effective the date the recommendations are published in the CDC’s Morbidity and Mortality Weekly Report.

The human papillomavirus (HPV) vaccine is covered for all females ages 11–26 who have not completed the vaccine series, regardless of sexual activity or clinical evidence of previous HPV infection. The HPV vaccine is not covered after age 26. The HPV vaccine is not covered for males.

The TRICARE medical (not pharmacy) benefit covers a single dose of the shingles vaccine Zostavax®, administered in a provider’s office, for beneficiaries age 60 and older.

Refer to the CDC’s website at www.cdc.gov/vaccines for a current schedule of recommended vaccines.

**Note:** Immunizations required for ADFMs whose sponsors have permanent change of station orders to overseas locations are also covered. You must include a copy of the sponsor’s change of station orders when filing the claim. TRICARE does not cover immunizations for personal overseas travel.

### Hearing

Hearing examinations are covered under the well-child care benefit. All neonates should undergo audiology screening before leaving the hospital. If they are not tested at birth, infants should undergo audiology screening before one month of age. Infants who do not pass the screening should be tested before three months of age using Evoked Otoacoustic Emission and/or Auditory Brainstem Response testing. Hearing evaluations may be performed for all children during routine exams. Refer children with possible hearing impairment for appropriate testing.
**Infectious Disease Screening/Prophylaxis**

Covered screenings for infectious diseases include tuberculosis for individuals at high risk, rubella antibodies for females age 12-18 and HIV and hepatitis B (for pregnant women only and when done in conjunction with routine pre-operative services). Services for patients at risk for tetanus (following injury) or rabies (following an animal bite) are covered. Prophylaxis is covered for individuals with a verified exposure to hepatitis A, hepatitis B, meningococcal meningitis and tuberculosis. Routine HPV and HIV screening are not covered.

**Patient and Parent Education Counseling**

The following 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

**School Physicals**

TRICARE covers school physicals for children ages 5–11 if required in connection with school enrollment.

**Note:** Annual sports physicals are not covered.

**Well-Child Care**

The TRICARE well-child benefit (birth to age 6) covers routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight and head circumference measurement; routine immunizations; and developmental and behavioral appraisal. TRICARE covers well-child care in accordance with American Academy of Pediatrics® (AAP) and CDC guidelines. An eligible child can receive well-child preventive care visits as frequently as the AAP recommends. Visits for diagnosis or treatment of an illness or injury are covered separately under outpatient care.

**Pediatric Blood Lead Exposure Testing**

If a child is at high risk for lead exposure, according to a structured questionnaire developed from the CDC, TRICARE covers a blood lead level screening during each well-child visit from 6 months of age through 6 years of age.

**Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)**

**Prior Authorization for DMEPOS**

- **TRICARE Standard**—No authorization is required for TRICARE-covered DMEPOS (including capped rental items); however, a certificate of medical necessity (CMN) may be required, as discussed below.
- **TRICARE Prime**—Access the Prior Authorization, Referral and Benefit Tool at [www.hnfs.com](http://www.hnfs.com) to determine if a particular DMEPOS HCPC or CPT code requires prior authorization.

**Certificate of Medical Necessity for DMEPOS**

If authorization is not required, the submitting provider must include a CMN with the claim in the following circumstances:

- For a TRICARE Standard beneficiary who requires DMEPOS with a purchase price greater than $150
- For a TRICARE Prime beneficiary who requires DMEPOS with a purchase price greater than $150
- If the DMEPOS is a rental

No specific CMN form is required; however, the CMN should include the following information:

- Type of DMEPOS (including procedure codes and any special features or accessories)
• Diagnosis/reason for the DMEPOS
• Duration of time DMEPOS is needed
• Start date/prescribing date
• Provider’s signature (must be a doctor of medicine or a doctor of osteopathic medicine; may not be a podiatrist, physician assistant or nurse practitioner)

For more information about DMEPOS, visit www.hnfs.com or refer to the TRICARE Policy Manual, Chapter 8, Section 2.1, at http://manuals.tricare.osd.mil. See the TRICARE Reimbursement Methodologies section of this handbook for more information about DMEPOS reimbursement guidelines.

Emergency Services

TRICARE defines an emergency as a medical, maternity or psychiatric condition that would lead a “prudent layperson” (someone with average knowledge of health and medicine) to believe that a serious medical condition exists; that the absence of immediate medical attention would result in a threat to life, limb or sight; that a person has severe, painful symptoms requiring immediate medical attention to relieve suffering; or when a person is at immediate risk to self or others.

Prior authorization is not required for emergency care. However, all TRICARE Prime beneficiaries should notify their PCM of the emergency care, and they must coordinate any follow-up care with their PCM. Failure to coordinate follow-up care with their PCM may result in higher cost-shares.

Emergency Admissions

While prior authorization is not required for emergency room care, if the patient is admitted, authorization may be required.

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

Once Health Net receives the hospital admission record face sheet, a Health Net medical management representative contacts the hospital to obtain clinical information and discuss discharge planning. The representative also provides his or her contact information to the hospital for follow-up. After the representative obtains clinical information, Health Net issues a tracking number and an “average length of stay” goal, and then sends this information to the hospital.

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

If Health Net does not receive the requested clinical information, or if it is determined during the hospital stay that care is no longer medically necessary, Health Net issues a denial letter at least 24 hours before the coverage denial goes into effect.

Note: Emergency dental care services and dental X-rays are excluded except authorized adjunctive dental care (i.e., dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition). See “Adjunctive Dental Care” earlier in this section.
Home Health Care

TRICARE home health care benefits are similar to those covered under Medicare. TRICARE covers part-time (up to 28 hours per week) or intermittent (up to 35 hours per week) skilled nursing and home health care services. All care must be provided by a participating home health care agency and prior authorization from Health Net is required.

The home health care plan may cover the following:

- Physical or occupational therapy, or speech-language pathology services
- Physician-directed medical social services
- Routine and non-routine medical supplies
- Hospital care involving equipment that cannot be brought into the home

Assistance with daily living activities (laundry, cleaning dishes, etc.) is not part of the home health care benefit. While home health care professionals may provide assistance with basic daily living care, this assistance is considered ancillary and is not the professional’s primary duty while in the patient’s home.

For more information about home health care, refer to the TRICARE Reimbursement Manual, Chapter 12, at http://manuals.tricare.osd.mil. For information about home health care benefits related to the TRICARE Extended Care Health Option (ECHO) program, refer to the TRICARE Policy Manual, Chapter 9, Section 15.1.

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

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 diagnoses of less than six months to live if the terminal illness runs its normal course. Hospice 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 accepts 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 the beneficiary signs the hospice election statement and both the attending physician and the hospice medical director sign the physician’s certificate of terminal illness. The final benefit period consists of 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.

The TRICARE hospice benefit covers four levels of care: routine home care, continuous home care, inpatient respite care and general hospice inpatient care.

Note: Respite care is covered when necessary and is limited to no more than five days at a time. General inpatient care is limited to varying short-term stays.

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 may shift among all four, depending on their needs, the needs of family members caring for them and medical-team determinations.

Care may include:

- Counseling
- Medical equipment, supplies and medications
- Medical social services
- Medically necessary short-term inpatient care
• Nursing care
• Other covered services related to the terminal illness
• Physical and occupational services
• Physician services
• Speech and language pathology

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.

A beneficiary who elects to receive care under a hospice program cannot receive other TRICARE services/benefits (including curative treatment related to the terminal illness) unless the hospice care has been formally revoked. The hospice care 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 regular TRICARE benefits.

**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. Hospice patients cannot receive other TRICARE services/benefits (*curative treatments related to the terminal illness*) unless they formally revoke hospice care. TRICARE only covers care that the hospice provides or arranges.

To formally revoke the hospice election, the beneficiary must submit a signed, dated statement to the hospice provider. If the beneficiary revokes hospice, he or she forfeits the remaining days in the election period. At a later time, the beneficiary may initiate hospice coverage for any other election periods for which he or she is eligible. The hospice patient may change hospice providers only once per election period.


**Hospice Care Settings**

Patients may receive hospice care in a number of settings: at home, in a hospice facility, in a 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 cost-shares for items that the basic TRICARE program does not cover, such as medications, biologicals and inpatient respite care.

**Hospitalization**

TRICARE covers hospitalization services, including general nursing; hospital, physician and surgical services; meals (*including special diets*); drugs and medications; operating and recovery room care; anesthesia; laboratory tests; X-rays and other radiology services; medical supplies and appliances; and blood and blood products. Semiprivate rooms and special care units may be covered if medically necessary.

**Note:** Surgical procedures designated “inpatient only” may only be covered when performed in an inpatient setting. Please refer to inpatient procedures as published on [www.TRICARE.osd.mil](http://www.TRICARE.osd.mil).
Maternity Care

Maternity care includes medical services related to prenatal care, labor and delivery, and postpartum care. TRICARE-eligible women 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 notification to Health Net for TRICARE Prime, TPR, and TPRADFM beneficiaries to assist in coordinating services for potential high-risk pregnancies.

If your patient intends to deliver in a network (non-MTF) facility or birthing center, you must provide Health Net with authorization at the time of delivery. If the patient is a TRICARE Prime beneficiary, she must use a network facility for delivery. Length of stay cannot be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section.

Covered services include:

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

The following services are not covered:

- Fetal ultrasounds that are not medically necessary (e.g., to determine the baby’s sex), including three- and four-dimensional ultrasounds
- Services and supplies related to noncoital reproductive procedures (e.g., artificial insemination, in-vitro fertilization and other such reproductive technologies)
- Management of uterine contractions with drugs that are not U.S. Food and Drug Administration-approved for that use (i.e., off-label use)
- Home uterine activity monitoring and related services
- Unproven procedures (e.g., lymphocyte or paternal leukocyte immunotherapy to treat recurring miscarriages, salivary estriol test for preterm labor)
- Umbilical cord blood collection and storage, except when stem cells are collected for subsequent use in the treatment of tumor, blood or lymphoid disease
- Private hospital rooms (TRICARE generally does not cover private rooms; however, some MTFs may have private postpartum rooms)


Maternity Ultrasounds

TRICARE covers professional and technical components of medically necessary fetal ultrasounds as well as the maternity global fee. TRICARE covers medically necessary maternity ultrasounds that may be needed to:

- Estimate gestational age due to unknown date of last menstrual period, irregular periods, size/date different by greater than two weeks or pregnancy while on oral contraceptive pills

Note: Estimated gestational age confirmation is not a medically necessary indication.

- Evaluate fetal growth when the fundal height growth is significantly greater than expected (more than 1 cm per week) or less than expected (less than 1 cm per week)
• Conduct a biophysical evaluation for fetal well-being when the mother has certain conditions (e.g., insulin-dependent diabetes mellitus, hypertension, systemic lupus, congenital heart disease, renal disease, hyperthyroidism, prior pregnancy with unexplained fetal demise, multiple gestations, post-term pregnancy after 41 weeks, intrauterine growth retardation, oligohydramnios or polyhydramnios, preeclampsia, decreased fetal movement, isoimmunization)
• Evaluate a suspected ectopic pregnancy
• Determine the cause of vaginal bleeding
• Diagnose or evaluate multiple births
• Confirm cardiac activity (e.g., when heart rate is not detectable by Doppler and/or suspected fetal demise)
• Evaluate maternal pelvic masses or uterine abnormalities
• Evaluate suspected hydatidiform mole
• Evaluate the condition of the fetus in late registrants for prenatal care

Note: You must issue a secondary diagnosis to establish medical necessity for an ultrasound performed under a diagnosis of supervision of normal pregnancy. Otherwise, TRICARE will not reimburse the claim. A primary prenatal care provider who refers a patient to another provider for an ultrasound must provide the diagnosis (medical indication) to the rendering provider to justify medical necessity.

Ultrasonography should be performed only when there is a valid medical indication. A physician is not obligated to perform ultrasonography for a low-risk patient with no medical indications.

Some providers offer routine ultrasound screening as part of the scope of care after 16–20 weeks of gestation. TRICARE does not cover routine ultrasound screening. TRICARE only covers maternity ultrasounds with valid medical indications that constitute medical necessity. If the beneficiary and provider agree to perform an ultrasound that is not considered medically necessary, the provider may only directly bill the beneficiary under certain conditions. For more information, see “Informing Beneficiaries about Non-Covered Services” and “TRICARE’s Hold Harmless Policy” under “Provider Responsibilities” in the Important Provider Information section of this handbook.

For more information about maternity care, refer to the TRICARE Policy Manual, Chapter 4, Section 18.1, at http://manuals.tricare.osd.mil. For ultrasound coverage updates, visit the Health Net website at www.hnfs.com.

Skilled Nursing Facility Care

TRICARE covers care at Medicare-certified, TRICARE-participating SNFs in semiprivate rooms. TRICARE covers regular nursing services: meals (including special diets); physical, occupational and speech therapy; drugs furnished by the facility, necessary medical supplies and appliances. TRICARE covers an unlimited number of days as medically necessary; semiprivate room coverage may be available. It also covers skilled nursing care and rehabilitative (physical, occupational and speech) therapies, room and board, prescribed drugs, laboratory work, supplies, appliances and medical equipment.

TRICARE only covers SNF admissions when all of the following are met:
• The beneficiary has a qualifying hospital stay of at least three consecutive days (not including the discharge day)
• Is admitted to the SNF within 30 days of discharge from the hospital
• The medical documentation demonstrates the patient’s need for skilled nursing services

Respite Care for Active Duty Service Members

TRICARE covers respite care for ADSMs who are homebound as a result of a serious injury or illness incurred while serving on active duty. Respite care is available if the ADSM’s plan of care includes frequent interventions by the primary caregiver. “Frequent” means that more than two interventions are required during the eight-hour period per day that the primary caregiver would normally be sleeping.

The following limits apply:

- 40 hours per calendar week
- Five days per calendar week
- Eight hours per calendar day

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 (i.e., MMSO or referring MTF). The ADSM is not required to be enrolled in the TRICARE Extended Care Health Option program to receive this respite benefit, and there are no copayments, cost-shares or dollar maximums.

Urgent Care

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

TRICARE Prime Urgent Care

In most cases, TRICARE Prime, TPR and TPRADFM beneficiaries can receive urgent care from their PCMs by making same-day appointments. If beneficiaries do not coordinate urgent care with their PCMs or Health Net, care is covered under the point of service (POS) option, resulting in higher out-of-pocket costs. If beneficiaries are away from home and cannot wait until they return home to see their PCMs, they must contact their PCMs for referrals, or call Health Net for assistance before receiving urgent care.

The POS option does not apply to ADSMs, children for the first 60 days following birth or adoption, the first eight outpatient behavioral health care visits to a network provider per fiscal year (October 1–September 30), emergency care or beneficiaries with other health insurance.

Limitations

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

The following listed services are covered with significant limitations:

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

Botulinum Toxin A injections for cosmetic procedures, myofacial pain, fibromyalgia and headaches are not covered. Cost-sharing may apply for injections to treat severe primary axillary hyperhidrosis, dystonia-related blepharospasm or strabismus, cervical dystonia or cerebral palsy-related spasticity. TRICARE may also consider off-label cost-sharing for Botox® injections used to treat chronic anal fissure (if unresponsive to conventional therapeutic measures).

Breast pumps, hospital-grade (E0604) electric, (including services and supplies related to the use of the pump) for mothers of premature infants are covered. A premature infant is defined as a newborn born at less than 37 weeks gestation. An electric breast pump is covered while the premature infant remains hospitalized during the immediate postpartum period. Hospital-grade electric breast pumps may also be covered after the premature infant is discharged from the hospital for a physician-documented medical reason. This documentation is also required for premature infants delivered in non-hospital settings. Breast pumps of any type, when used for reasons of personal convenience, are excluded even if prescribed by a physician. Manual breast pumps (E0602) and basic (non-hospital grade) electric pumps (E0603) are also excluded.
Cardiac rehabilitation may be covered for hospital-based acute rehabilitation, including inpatient hospitalization and up to 36 outpatient sessions per cardiac event. One of the following events must have occurred in the preceding 12 months:

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

Chiropractic care coverage is limited to ADSMs and is only available at specific MTFs under the Chiropractic Care Program. For more information, visit the TRICARE website at www.tricare.mil/chiropractic.

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

Dental care services and dental X-rays are excluded except authorized adjunctive dental care (i.e., dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition). See “Adjunctive Dental Care” in this section.

Diagnostic genetic testing is covered if medically proven and appropriate diagnostic genetic testing results influence a patient’s medical management. Services should be billed using the appropriate Evaluation and Management codes. Refer to the TRICARE Policy Manual, Chapter 6, Section 3.1, at http://manuals.tricare.osd.mil. For antepartum services, refer to the TRICARE Policy Manual, Chapter 4, Section 18.2.

Education and Training are only covered under the TRICARE ECHO and diabetic self-management training services. Diabetic self-management training services must be performed by programs approved by the American Diabetes Association.® The provider’s “Certificate of Recognition” from the American Diabetes Association must accompany the claim for reimbursement. See the TRICARE Policy Manual, Chapter 8, Section 7.1 for policy on Nutritional Therapy.

Eyeglasses are available to ADSMs at MTFs at no cost. For all other beneficiaries, the following are covered:

- Contact lenses and/or eyeglasses for treatment of infantile glaucoma
- Corneal or scleral lenses for treatment of keratoconus
- Scleral lenses to retain moisture when normal tearing is not present or is inadequate
- Corneal or scleral lenses to reduce corneal irregularities other than astigmatism
- Intraocular lenses, contact lenses, or eyeglasses for loss of human lens function resulting from intraocular surgery, ocular injury or congenital absence

Note: Adjustments, cleaning and repairs for eyeglasses are not covered.

Gastric bypass, gastric stapling, gastroplasty or laparoscopic adjustable gastric banding (Lap-Band® surgery)—to include vertical banded gastroplasty is covered when one of the following conditions is met:

- The patient is 100 pounds over the ideal body weight for height and bone structure and has one of these associated medical conditions: diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.
- The patient is 200 percent or more of the ideal body weight for height and bone structure. An associated medical condition is not required for this category.
- The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown).
Genetic testing is only covered when medically proven and appropriate, and when the results of the test will influence the medical management of the patient.

Hearing aids and certain repairs are covered for ADFMs who meet specific hearing loss requirements. TRICARE coverage excludes any fully implantable hearing aid that has no visible parts. However, semi-implantable hearing aids such as bone anchored hearing aids (BAHAs) may be covered for beneficiaries who meet coverage criteria. For additional details on hearing aid coverage, refer to the TRICARE Policy Manual, Chapter 7, Section 8.2 at http://manuals.tricare.osd.mil.

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

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

Nutritional therapy (i.e., enteral or parenteral nutrition therapy) is covered when medically justified as the primary source of nutrition.

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

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

Shoes, shoe inserts, shoe modifications and arch supports are covered only in very limited circumstances. Orthopedic shoes may be covered if they are a permanent part of a brace. For individuals with diabetes, extra-depth shoes with inserts or custom-molded shoes with inserts may be covered. For more information, please visit www.hnfs.com.

Legend vitamins specifically used to treat medical conditions may be cost-shared. In addition, prescription prenatal vitamins for prenatal care may be cost-shared.

Exclusions

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

The following specific services are excluded under all circumstances. This list is not all-inclusive. Visit www.tricare.mil for additional information.

- Acupuncture
- Alterations to living spaces
- Artificial insemination, including in vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies
- Autopsy services or postmortem examinations
- Birth control/contraceptives (non-prescription)
- Bone marrow transplants for treatment of ovarian cancer
- Camps (e.g., for weight loss)
- Care or supplies furnished or prescribed by an immediate family member
- Charges that providers may apply to missed or rescheduled appointments
- Counseling services that are not medically necessary for the treatment of a diagnosed medical condition (e.g., educational, vocational and socioeconomic counseling; stress management; lifestyle modification)
- Custodial care
- Diagnostic admission
- Domiciliary care
- Dyslexia treatment
- Electrolysis
- Elevators or chairlifts
• Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club memberships or other such charges or items
• Experimental or unproven procedures
• Food, food substitutes and nutritional supplements
• Foot care (routine), except if required as a result of a diagnosed, systemic medical disease affecting the lower limbs, such as severe diabetes
• General exercise programs, even if recommended by a physician and regardless of whether rendered by an authorized provider
• Inpatient stays:
  • For rest or rest cures
  • To control or detain a runaway child, whether or not admission is to an authorized institution
  • To perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis
  • In hospitals or other authorized institutions above the appropriate level required to provide necessary medical care
• Learning disability service
• Medications:
  • Drugs prescribed for cosmetic purposes
  • Fluoride preparations
  • Homeopathic and herbal preparations
  • Multivitamins
  • Over-the-counter products (except insulin and diabetic supplies)
• Weight-reduction products
  • Megavitamins and orthomolecular psychiatric therapy
  • Mind expansion and elective psychotherapy
  • Naturopaths
• Non-surgical treatment of obesity or morbid obesity
• Personal, comfort or convenience items, such as beauty and barber services, radio, television and telephone
• Postpartum inpatient stay for a mother to stay with a newborn infant (usually primarily for the purpose of breastfeeding the infant) when the infant (but not the mother) requires the extended stay, or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay
• Preventive care, such as routine, annual or employment-requested physical examinations; routine screening procedures; or immunizations, except as provided under the clinical preventive services benefit (see “Clinical Preventive Services” earlier in this section).
• Psychiatric treatment for sexual dysfunction
• Services and supplies:
  • Provided under a scientific or medical study, grant or research program
  • For which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor were not TRICARE-eligible
  • Furnished without charge (i.e., cannot file claims for services provided free-of-charge)
  • For the treatment of obesity, such as diets, weight-loss counseling, weight-loss medications, wiring of the jaw or similar procedures (for gastric bypass see “Limitations” earlier in this section).
  • Inpatient stays directed or agreed to by a court or other governmental agency (unless medically necessary)
  • Required as a result of occupational disease or injury for which any benefits are payable under a workers’ compensation or similar law, whether such benefits have been applied for or paid, except if benefits provided under these laws are exhausted
• That are (or are eligible to be) fully payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (in such instances, TRICARE is the secondary payer for any remaining charges).

• Sex changes or sexual inadequacy treatment, with the exception of treatment of ambiguous genitalia that has been documented to be present at birth

• Sterilization reversal surgery

• Surgery performed primarily for psychological reasons (such as psychogenic surgery)

• Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE

• Transportation except by ambulance

• X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms, except for cancer-screening mammography, cancer screening, Pap smears and other tests allowed under the clinical preventive services benefit
Behavioral Health Care Services

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

Behavioral Health Care Providers

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

The TRICARE behavioral health care outpatient network consists of TRICARE-authorized providers, including 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. The TRICARE behavioral health care inpatient network consists of hospitals, inpatient psychiatric units, partial hospitalization programs (PHPs), residential treatment centers (RTCs) and substance use disorder rehabilitation facilities (SUDRFs).

Freestanding PHPs, RTCs and SUDRFs must be TRICARE-authorized by the TRICARE Quality Monitoring Contractor, Keystone Peer Review Organization, Inc. (KêPRO) and sign participation agreements to comply with all TRICARE policies. For more information, refer to the Important Provider Information section of this handbook, visit www.hnfs.com or call Health Net at 877-TRICARE (877-874-2273).

Referral and Authorization Requirements

TRICARE referral and authorization requirements vary according to several factors, including, but not limited to, beneficiary type, program option and type of care. All ADSMs should seek care at an MTF for behavioral health needs. For TRICARE Prime beneficiaries, the Primary Care Manager (PCM) is responsible for obtaining required referrals and prior authorizations from Health Net. TRICARE Prime beneficiaries should start with their PCMs. All have behavioral health training and can either assist or refer to the most appropriate resource.

Referral and prior authorization requirements for specific services are provided later in this section, but the following general guidance applies:

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

- **Outpatient behavioral health care**—Except for ADSMs, TRICARE beneficiaries do not need a referral or prior authorization for the first eight outpatient behavioral health care visits to network providers per fiscal year (FY) (October 1–September 30). After the initial eight visits, prior authorization is required.

  **Note:** TRICARE only covers one initial evaluation—either a psychiatric diagnostic exam (Current Procedural Terminology code [CPT] code 90801) or an interactive diagnostic exam (CPT code 90802)—per FY. This initial evaluation does not count toward the first eight self-referred outpatient visits. Additional evaluations require prior authorization from Health Net.
• Visits to licensed or certified mental health and pastoral counselors—Physician referrals (i.e., seeing the patient, performing an evaluation and making an initial diagnosis before referring the patient) and supervision (i.e., providing overall medication management and regularly communicating with the counselor about the treatment plan) are required for all visits (including the first eight outpatient visits) to licensed or certified mental health and pastoral counselors. The counselor should keep a copy of the referral in the patient’s chart. When filing a claim, the counselor must indicate the referring physician’s name in Box 17/17a/17b of the claim form to certify that he or she reported (or will report), in writing, treatment results to the referring physician, as requested.

• Non-emergency inpatient behavioral health care—All non-emergency inpatient care requires a referral and prior authorization from Health Net. TRICARE Standard beneficiaries must also obtain a nonavailability statement (NAS) for a non-emergency inpatient admission. See Nonavailability Statements later in this section.

Note for ADSMs: ADSMs should receive behavioral health care at an MTF whenever possible. ADSMs must have referrals and/or prior authorizations from their PCMs and Health Net before seeking non-emergency behavioral health care. TRICARE Prime Remote (TPR) ADSMs must obtain prior authorizations from Health Net and their service point of contact (SPOC).

Note for TRICARE For Life (TFL) beneficiaries: TFL beneficiaries should follow Medicare rules. If TRICARE is the primary payer (e.g., for services Medicare does not cover, if Medicare benefits are exhausted), beneficiaries should follow TRICARE rules.

888-299-4181 (outpatient) or 877-809-8667 (inpatient). To download the form go to www.hnfs.com or call Health Net at 877-TRICARE (877-873-2273) to request a copy.

Note: Network providers who submit claims without prior authorization may be subject to a 10 percent penalty of the TRICARE-allowable charge.

Accessing Behavioral Health Care

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

Outpatient Services

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

As a reminder, the following referral and prior authorization requirements apply to outpatient behavioral health care, unless otherwise noted:

• Non-ADSMs may self-refer for the first eight outpatient behavioral health care visits to network providers per FY. Visits beyond the initial eight self-referred visits require medical necessity reviews and prior authorization from Health Net.

• ADSMs must have PCM referrals, or SPOC referrals if enrolled in TPR, to obtain civilian care. Prior authorization may also be required.

• A physician referral and supervision is required for any visit to a licensed or certified mental health or pastoral counselor. See “Referral and Authorization Requirements” earlier in this section for details.
Outpatient Psychotherapy

TRICARE covers medically necessary outpatient psychotherapy used to treat diagnosed behavioral health disorders. Services must be rendered by qualified, TRICARE-authorized behavioral health care providers practicing within the scopes of their licenses. For information about the requirements for being an authorized TRICARE Provider, refer to the TRICARE Policy Manual, Chapter 11 at http://manuals.tricare.osd.mil/.

The following rules apply:

- A provider cannot bill for more than two sessions per calendar week (Sunday–Saturday) without prior authorization from Health Net.
- When multiple sessions of the same type are conducted on the same day (e.g., two individual sessions or two group sessions), only one session is reimbursed.

Note: A collateral session may be conducted on the same day the beneficiary receives individual therapy.

- Two psychotherapy sessions may not be combined to circumvent limits (e.g., 30 minutes on one day may not be added to 20 minutes on another day and counted as one session).

The following outpatient psychotherapy coverage limits apply:

- Psychotherapy—Two sessions per week, in any combination of the following types:
  - Individual (adult or child): Sixty minutes per session; may extend to 120 minutes for crisis intervention
  - Family or conjoint: Ninety minutes per session; may extend to 180 minutes for crisis intervention
  - Group: Ninety minutes per session
  - Collateral visits (limited benefit)
  - Psychoanalysis (limited benefit)

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

Marriage Counseling and Family Therapy

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

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

Outpatient therapy is limited to a maximum of two sessions per week in any combination of individual, family or collateral sessions. Family therapy is considered under the initial eight self-referred outpatient behavioral visits. All visits beyond the initial eight require prior authorization from Health Net. Behavioral health services rendered by a physician assistant (PA) are not covered under TRICARE.

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

Additional resources for marriage counseling and family therapy include:

- Military OneSource—Offers cost-free, confidential counseling sessions to eligible military personnel and their family members. Counseling is available in person or by phone and addresses short-term issues, such as grief and loss, deployment adjustment, work/life management, and combat stress. Visit www.militaryonesource.com or call 800-342-9647.
• **Military & Family Life Consultants (MFLCs)—** Provides direct, face-to-face, non-medical counseling and education regarding daily life stressors related to deployment and reintegration. The counselors address concerns of stress, relationships, family problems, financial issues, grief and loss, conflict resolution and the emotional challenges of reintegrating into a non-combat environment. Visit www.mhngs.com or call 800-646-5613.

• **Health Net’s Online Behavioral Health Resource Center—** Designed to help balance work, family and other aspects of life, the Online Behavioral Health Resource Center at www.hnfs.com is available in both English and Spanish, and offers comprehensive articles, information sheets, quick tips, calculators and more.

• **Local Military Treatment Facility**—Beneficiaries can check with their local MTFs to see if marriage counseling is a benefit offered through the MTF.

• **Community Based Services**—Beneficiaries can check in their community to see if any city, county or state sponsored behavioral health services, social service agencies, community groups or church-based couples/family services are available in the area.

**Psychological Testing and Assessment**

TRICARE covers medically necessary testing and assessment when provided in conjunction with otherwise-covered psychotherapy. Psychological tests are covered as diagnostic services and do not count toward the limit of two psychotherapy visits per week.

The following rules apply:

- Psychological testing is generally limited to six hours per year.
- Neuropsychological testing is generally limited to 12 hours per year.

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

Psychological testing is not covered for the following circumstances:

- Academic placement
- Job placement
- Child-custody disputes

• **General screening in the absence of specific symptoms**
• **Teacher or parental referrals**
• **Diagnosed specific learning disorders or learning disabilities**
• **For the Reitan-Indiana battery when administered to a patient under age 5 and for self-administered tests to a patient under age 13**

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

**Medication Management**

TRICARE covers medication management provided as an independent procedure when rendered by a provider who is authorized to prescribe the medication. Medication management does not require prior authorization from Health Net. However, a referral may be required for TRICARE Prime beneficiaries and prior authorization is required for medication management provided in conjunction with therapy services. For more information about medication management, refer to the TRICARE Policy Manual, Chapter 7, Section 3.15, at http://manuals.tricare.osd.mil/.

**Electroconvulsive Therapy**

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

**Inpatient Services**

All non-emergency inpatient admissions require prior authorization from Health Net. A TRICARE Standard beneficiary may also have to obtain an non-availability statement before receiving non-emergency inpatient care.
Acute Inpatient Psychiatric Care

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

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

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

Partial Hospitalization Program Care

Psychiatric PHPs provide interdisciplinary therapeutic services at least three hours a day, five days a week, in any combination of day, evening, night and weekend treatment programs. A full-day program lasts at least six hours, and a half-day program lasts between three and five hours. PHPs employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. PHP care is appropriate for crisis stabilization, treatment of partially stabilized mental health disorders or transitioning a patient from an inpatient program when medically necessary.

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

- **Acute Care Hospital-based PHP** — Does not need separate TRICARE certification from KêPRO. A PHP that is part of a TRICARE-authorized hospital is also considered TRICARE-authorized and must be certified by The Joint Commission.
- **Freestanding PHP** — Must be TRICARE-certified by KêPRO and must enter into a participation agreement with TRICARE. See the Important Provider Information section of this handbook for more information.

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

The following coverage limitations apply:

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

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

- The 60 PHP treatment days are not offset by, nor counted toward, the 30- or 45-day inpatient limit.

Partial Hospitalization Program Claims

TRICARE reimburses outpatient service claims, including claims for hospital-based PHPs (psychiatric and SUDRFs) subject to TRICARE prior authorization requirements, national per diem Ambulatory Payment Classification (APC) payments under the outpatient prospective payment system (OPPS). The OPPS is mandatory for both network and non-network providers. TRICARE follows Medicare’s reimbursement methodology, which uses two separate APC payment rates to reimburse hospital-based PHP claims:

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

When billing hospital-based PHP care under OPPS, list the appropriate Healthcare Common Procedure Coding System (HCPCS) and revenue codes separately for each service date. Report PHP services under bill type 013X and with condition code 41 on a UB-04 claim form. The claim must also include a behavioral health primary diagnosis and an authorization for each service date.

TRICARE continues to reimburse free-standing PHP claims under the current per diem rate schedule. The per diem rate includes the provider’s overhead costs, support staff, and clinical social worker and occupational therapist professional services. The SUDRF per diem rate includes alcohol and addiction counselor services. Bill PHP care on UB-04 forms and use the following codes:

- **Revenue Code 912** — Psychiatric Partial Hospitalization, all-inclusive per diem payment of three to five hours (half-day program)
- **Revenue Code 913** — Psychiatric Partial Hospitalization, all-inclusive per diem payment of six or more hours (full-day program)
For more information about PHPs, refer to the TRICARE Reimbursement Manual, Chapter 7, Section 2, at http://manuals.tricare.osd.mil. To learn more about OPPS, refer to the TRICARE Reimbursement Methodologies section of this handbook or the TRICARE Reimbursement Manual, Chapter 13, Section 2, or call Health Net at 877-TRICARE (877-874-2273).

**Residential Treatment Center Care**

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

The following rules apply:

- RTC care is considered elective (non-emergency) and always requires prior authorization from Health Net.
- Freestanding PHP facilities must be TRICARE-authorized by KēPRO (see the Important Provider Information section of this handbook for contact information)
- Unless therapeutically contraindicated, the family and/or guardian should actively participate in the continuing care of the patient through either direct involvement at the facility or geographically distant family therapy.
- Admission primarily for substance use rehabilitation is not authorized.
- A psychiatrist or clinical psychologist must recommend and direct care.

The following coverage limitations apply:

- Care is limited to 150 days per FY or for a single admission.
- RTC care is only covered for patients up to age 21. Health Net may approve additional hours on a case-by-case basis.

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

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

**Substance Use Disorder Services**

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

**Inpatient Detoxification**

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

The following limits apply:

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

**Inpatient Rehabilitation**

Rehabilitation (residential or partial) is limited to 21 days per year, per benefit period.* All inpatient stays count toward the 30- or 45-day inpatient limit.

- Benefits include 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.

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 always required for rehabilitation stays.
- 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 per benefit period*
  - Three treatment episodes during a person’s lifetime
  - An inpatient rehabilitation stay counts toward the 30- or 45-day inpatient limit.
  - A partial hospitalization rehabilitation stay counts toward the 60-day psychiatric PHP limit.

TRICARE shares the cost of this partial hospitalization rehabilitation treatment for up to 21 days at a predetermined, all-inclusive per diem rate.

* A benefit period starts the first day of covered treatment and ends 365 days later.

**Outpatient Care**

Outpatient care must be provided by an approved substance use disorder rehabilitation facility or SUDRF.

The following coverage limits apply:

- Individual or group therapy—60 visits per benefit period
- Family therapy—15 visits per benefit period
- PHP care—21 treatment days per FY

Health Net may approve additional hours on a case-by-case basis. TRICARE does not cover non-facility-based outpatient services provided in an office-based setting for a beneficiary with a primary diagnosis of substance use disorder/dependence.

**Note:** A benefit period starts the first day of covered treatment and ends 365 days later.

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**Behavioral Health Care Provider and Appointment Assistance Line**

The Health Net Federal Services, LLC (Health Net) Behavioral Health Care Provider Locator and Appointment Assistance Line helps eligible beneficiaries locate behavioral health care providers and schedule urgent and routine behavioral health care appointments. Active duty service members and ADFMs enrolled in TRICARE Prime, TRICARE Prime Remote or TRICARE Prime Remote for ADFMs may call the appointment assistance line to locate providers and schedule outpatient appointments. Active duty service members must have referrals from their PCMs, service points of contact or MTF behavioral health clinics before calling the Behavioral Health Care Provider Locator and Appointment Assistance Line. Active duty service members are encouraged to seek care at MTFs whenever possible, which do not require referrals. However, if MTF care is not available, ADSMs should obtain referrals and call the line to schedule appointments with network providers.

The toll-free line, 877-747-9579, is available to eligible beneficiaries from 8 a.m. to 6 p.m. Eastern Time (7 a.m. to 5 p.m. Central Time), Monday through Friday, excluding holidays. This line is not for crisis intervention. Beneficiaries seeking emergency care should call 911 or go to the nearest emergency room.

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**TRICARE Assistance Program**

The TRICARE Assistance Program (TRIAP) is a Web-based program available to eligible beneficiaries. Active duty service members and their spouses of any age are eligible, but dependent family members, TRICARE Reserve Select beneficiaries and Transitional Assistance Management Program beneficiaries must be 18 or older. TRIAP provides online access to behavioral health care counseling for short-term, non-medical issues. Beneficiaries can contact licensed professionals 24 hours a day, seven days a week.
TRIAP enables beneficiaries to have private, solution-focused discussions with counselors about many personal life issues, including:

- Stress management (work, family, personal)
- Family difficulties and pressures
- Deployments and other family separations
- Relationships and marriage
- Parent-child communication
- Self-esteem

TRIAP services do not require a referral or authorization, but the beneficiary will need a phone, computer and webcam. Beneficiaries may access TRIAP an unlimited number of times, and services are confidential and non-reportable, with the following exception: if the TRIAP counselor believes the beneficiary is at risk of harming himself/herself or others, the counselor will request personal contact information in order to inform the beneficiary’s commander, or a service operations center, to ensure the beneficiary receives appropriate counseling and/or care. TRIAP does not provide medication management, financial services or emergency care. For more information about TRIAP benefits, access and technology requirements, visit www.hnfs.com, www.tricare.mil/triap or call 800-404-5085.

Telemental Health Program

The Telemental Health program uses secure, two-way audio-visual conferencing to connect stateside TRICARE beneficiaries with off-site TRICARE network providers. Telemental Health provides medically necessary behavioral health care services, including:

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

Telemental Health interaction may involve live, two-way audio-visual visits between patients and medical professionals. Beneficiaries can access Telemental Health services at TRICARE-authorized Telemental Health-participating facilities to contact TRICARE network providers at remote locations.

Behavioral health care limitations, authorization requirements, deductibles, and cost-shares apply. For more information, visit the “Mental Health and Behavior” Web page at www.tricare.mil. To schedule a Telemental Health appointment, call 877-747-9579.

Court-Ordered Care

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

Behavioral Health Care and Other Health Insurance

- TRICARE pays after a beneficiary’s other health insurance (OHI), including Medicare, employment-based coverage and other insurance policies and plans.
- If the OHI denies a claim because the beneficiary did not follow the OHI’s rules, TRICARE will also not pay.
- If services are denied by the patient’s OHI on the basis that the care is not medically necessary, TRICARE benefits can only be considered after all avenues of appeal available with the OHI have been pursued.
- Prior authorization is required for those services previously listed that will be billed to TRICARE, even when the beneficiary has OHI.

HIPAA Transaction Standards and Code Sets

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Transaction Standards and Code Sets regulations allow health care providers to electronically
verify patient eligibility, request authorizations and referrals, submit claims, check claims and request status. All health care providers, plans and clearinghouses are required to comply and must use the following standard formats for TRICARE behavioral health care claims:

- ASC X12N 837—Health Care Claim: Professional, Version 4010 and Addenda
- ASC X12N 837—Health Care Claim: Institutional, Version 4010 and Addenda

TRICARE contractors (i.e., Health Net and PGBA) and other health care payers are prohibited from accepting or issuing transactions that do not meet the new standards. To avoid future disruptions, all providers must convert to HIPAA-compliant claims formats. For more information on HIPAA Transaction Standards and Code Sets, see the Important Provider Information section of this handbook or visit the PGBA website at www.myTRICARE.com.

Behavioral Health Care Claim Tips

- File claims with PGBA within one year of the date of service.
- Behavioral health care includes the ICD-9/DSM-IV diagnosis range 290.0–314.9. Only physicians and other licensed or certified behavioral health care providers may bill for psychiatric CPT codes or ICD-9/DSM-IV diagnoses.
- Balance billing a beneficiary is not permitted.
- File hospital and other institutional care claims on UB-04 forms.
- File professional services claims on Centers for Medicare & Medicaid Services (CMS)-1500 forms.
- Professional providers should use CPT procedure codes and DSM-IV diagnosis codes to bill for services.
- Facilities should use revenue and HCPCS codes (if required) to bill for services.
- Properly inform beneficiaries in advance if services are not covered. You are financially responsible for any non-covered services you provide to a TRICARE beneficiary who was not properly informed in advance of non-coverage and/or who did not agree in advance and in writing to pay for the non-covered services. See “Informing Beneficiaries about Non-Covered Services” and “TRICARE’s Hold Harmless Policy” in the Important Provider Information section of this handbook for more information.
- Check claims status at www.hnfs.com, or call 877-TRICARE (877-874-2273). Claim check services are available 24 hours a day, seven days a week.
- If Health Net denies a claim because you did not obtain required authorization, follow instructions on the remittance statement or call Health Net at 877-TRICARE (877-874-2273) for assistance.

Non-Covered Behavioral Health Care Services

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

- Aversion therapy (including electric shock and the use of chemicals for alcoholism, except for Antabuse® [disulfiram], which is covered for the treatment of alcoholism)
- Behavioral health care services and supplies related solely to obesity and/or weight reduction
- Bioenergetic therapy
- Biofeedback for psychosomatic conditions
- Carbon dioxide therapy
- Counseling services that are not medically necessary in the treatment of a diagnosed medical condition (e.g., educational counseling, vocational counseling, nutritional counseling, stress management, marital therapy or lifestyle modifications)
- Custodial nursing care
- Diagnostic admissions
- Educational programs
- Environmental ecological treatments
- Experimental procedures
- Eye movement desensitization and reprocessing called 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
• Surgery performed primarily for psychological reasons (e.g., psychogenic)
• Telephone counseling (except for geographically distant family therapy related to RTC treatment)
• Therapy for developmental disorders, such as dyslexia, developmental mathematics disorders, developmental language disorders and developmental articulation disorders
• Training analysis
• Transcendental meditation
• Treatment for sexual perpetrators or predators
• Unproven drugs, devices and medical treatments or procedures
• Vagus nerve stimulation therapy
• Z therapy

• 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

**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:
Advance Directives

Hospitals and other health care providers are required under the federal Patient-Self-Determination Act to give patients information about their rights to make their own health care decisions. That includes the right to accept or refuse medical treatment.

The term “advance directive” can describe a variety of documents used to indicate a patient’s requests regarding medical care. Living Will and Health Care Power of Attorney documents are types of advance directives. Some states also have a document specifically called an Advance Health Care Directive. The term “advance directive” may be used to refer to any of these specific documents or all of them in general.

States differ widely on what types of advance directives they officially recognize. Some states also require that patients use a specific form for the format and content of his or her advance directive. Please inform your patients about advance directives and advise them to contact an attorney who is familiar with your state statutes regarding advance directives if they have questions or concerns.

Network Utilization

TRICARE network or military treatment facility (MTF) providers should be the first option in TRICARE patient care. In most cases, patient care can be arranged swiftly through TRICARE’s vast provider network while meeting access to care standards such as wait and drive time. TRICARE network and participating providers are expected to refer TRICARE Prime beneficiaries to TRICARE network providers. Requests for specialty care referrals or outpatient treatment authorization to a non-network provider will be redirected to the MTF or a TRICARE network provider.

If TRICARE Prime eligible beneficiaries choose to receive their health care from a non-network provider these services will be reimbursed under the beneficiary’s point of service option (POS).

All requests for a non-network referral or authorization must include specific medical necessity and justification information as to why a non-network provider must be used in lieu of a TRICARE network provider.

The TRICARE provider network directory can be found online at www.hnfs.com.

Referral Process

A referral is the process of sending a patient to another professional provider (physician or psychologist) for medically necessary consultations or health care services that the attending physician is not prepared or qualified to provide. Referral services are not considered primary care. An example of a referral is when a primary care manager (PCM) sends a patient to see a cardiologist to evaluate chest pain. Providers should keep in mind:

- Referral requirements are based on the beneficiary type (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 TRICARE Overseas Program (TOP) Prime or TOP Prime Remote, do not require a referral and authorization for care when traveling in the United States, and 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 beneficiaries enrolled in TRICARE Prime and TRICARE Prime Remote for Active Duty Family Members (TPRADFMs) must coordinate their referral through their PCM and network specialty care provider, except for
emergency care, preventive care services from network providers, the eight initial outpatient behavioral health care 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 referrals 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**—TRICARE For Life and dual-eligible beneficiaries do not require a referral or prior authorization from Health Net for health care services. These beneficiaries should follow Medicare rules for services requiring authorization. However, there are certain procedures that require prior authorization when TRICARE is the primary payer.

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

- **TRICARE Beneficiaries with Other Health Insurance**—If a beneficiary has other health insurance (OHI), the OHI is the primary payer before TRICARE. Beneficiaries (excluding ADSMs) with OHI 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 use the Prior Authorization, Referral and Benefit Tool located at [www.hnfs.com](http://www.hnfs.com) to determine if a Health Net referral is required.

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 referring the patient to the civilian network.

### Requesting Referrals from Health Net

Civilian providers can request a referral 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 at [www.hnfs.com](http://www.hnfs.com) to submit referral requests electronically for your convenience, the Online Authorization and Referral Submission Tool has an “auto population” feature that allows you to create a Requesting Provider Personal Directory that retains the requesting provider’s Tax Identification Number (TIN), 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 can track the status of their referrals via the Referral and Authorization Status Tool located on [www.hnfs.com](http://www.hnfs.com).

Network providers need to complete the TRICARE Service Request/Notification form if faxing a request. To access the form, go to [www.hnfs.com](http://www.hnfs.com). For your reference, a sample completed form and detailed instructions are also available on the site. To prevent delays in processing, remember these important guidelines when completing and faxing the form:

1. If filling out the form by hand, be sure to write legibly so all letters and numbers are clear.
2. Be sure to complete every section of the form—including clinical history/previous treatment and supporting test results—for Health Net to process the request in a timely fashion.
3. Once the form is complete, fax it to 888-299-4181 (outpatient) or 877-809-8667 (inpatient). Do not include a fax cover sheet.
4. Fax each patient referral request separately.

To prioritize referral requests, network providers should follow the guidelines listed in Figure 6.1. Health Net will contact the provider’s office for further information or clarification. If your office is not equipped with Internet access or a fax machine, you may request a referral from Health Net by calling 877-TRICARE (877-874-2273). If an MTF cannot provide care, Health Net will arrange for services within the civilian network.
**Prioritizing Referral Requests**

| When the care is required within 24 hours: | • Call Health Net for a telephone referral request at 877-TRICARE (877-874-2273).  
• Choose the option for “authorizations and referrals.”  
• Clearly state that the referral is urgent when speaking with the Health Net representative.  
• Do not send a fax or submit the request online. |
|---|---|
| When the care is required within 72 hours: | • Online—Submit the request using the Online Authorization and Referral Submission Tool at www.hnfs.com. Select “URGENT” when submitting your request.  
• By fax—Fax a completed TRICARE Service Request/Notification form without a cover sheet to 888-299-4181 (outpatient) or 877-809-8667 (inpatient). 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.hnfs.com.  
• By fax—Fax a completed TRICARE Service Request/Notification Form without a cover sheet to 888-299-4181 (outpatient) or 877-809-8667 (inpatient). |

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

Both civilian and MTF providers should:

- **Request services**—When a referral from Health Net is required, the PCM must include a written explanation of the services that are being requested to be performed by the specialist and sufficient clinical information to assist the specialist with their initial evaluation.

- **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 notice that lists the specialty provider’s name, specialty services and dates and/or visits that are approved. The beneficiary should use this information to schedule the first appointment with the specialist. If the beneficiary decides to see a network provider other than the one indicated on the referral, he or she does not need to notify Health Net of this change. If the beneficiary would like a referral notice with the name of the network provider they have selected, they may contact Health Net if the TRICARE Prime and TPRADFM beneficiary chooses a non-network provider, point of service (POS) charges will apply.

### Extending Referrals and Authorizations for Existing Care

Specialty referrals are valid for a specific period of time, which is provided on the Health Net authorization approval letter or fax. A referral for “Evaluation Only” is valid for 90 days from the date of issue. Referrals for “Evaluation and Treat” are valid for 180 days and only for the number of visits specified.

Specialists can make requests directly to Health Net to extend referrals or authorizations for existing episodes of care (e.g., requests for additional visits/days, changes of surgery dates). It is not necessary for the patient’s primary care manager (PCM) to request a new referral or authorization for an extension of services.

If you are a specialist who wishes to extend a referral or add services, there must be an “active” or previously approved referral or prior authorization in place. A referral or prior authorization is considered “active” if it is less than 180 days old for an active duty service member (ADSM) or less than 360 days old for a non-ADSM.

**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 if the request is for consultation only. The patient will need to coordinate ongoing specialty care with his or her PCM.
To request additional visits or services and extend an “active” referral or prior authorization, specialists must:

- Submit requests to Health Net via the online “Authorization and Referral Submission Tool” at www.hnfs.com or fax a TRICARE Service Request Notification form to 888-299-4181 (outpatient) or 877-809-8667 (inpatient)
- Provide Health Net with the original referral or authorization number assigned to that patient’s initial referral or authorization
- State that the request is for additional visits or services associated with the initial referral or authorization

**Note:** For speech, occupational and physical therapies, the specialist must contact the beneficiary’s PCM to obtain a new referral if the original referral to either the therapist or ordering specialty provider has exceeded 180 days for an ADSM or 360 days for a non-ADSM.

**Coordinating a Second Opinion**

Beneficiaries may contact you to schedule an appointment for a second opinion. The beneficiary has 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. Health Net must approve second opinions for TRICARE Prime beneficiaries in TRICARE PSAs.

When approved, second-opinion 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 a physician’s documented referral and supervision (a physician is defined as an M.D. or a 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 ADSMs). ADSMs always require a referral for civilian specialty care, including behavioral health care services.

If TRICARE Prime beneficiaries self-refer to a network provider without a referral from their PCM (for other than emergency services, clinical preventive services from network providers and the initial eight outpatient behavioral health care visits from network providers), 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 network provider.

**Referral Review Guidelines**

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

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

- Most 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
- Encourage the use of the TRICARE mail order pharmacy

The PCM may refer patients only when a specialist’s consultation and complex decision making are required.
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 requests must be submitted to Health Net prior to services being rendered. A prior authorization request initiates a review of certain medical, surgical, and behavioral health care services to ensure medical necessity and appropriateness of care. 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 also have a begin date and an end date.

Depending on the type of beneficiary (e.g., ADSM, TRICARE Prime beneficiary, TRICARE Standard beneficiary) requesting the service, TRICARE requires prior authorization for non-emergency inpatient and some outpatient services. 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, providers 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 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 in accordance with Health Net and TRICARE policy to evaluate medical and behavioral health care trends and to better control health care costs for the government.

Services Requiring Prior Authorization

Since prior authorization requirements are subject to change, Health Net created the Prior Authorization, Referral and Benefit Tool. Providers can enter a service into the tool and receive a response on whether or not 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 877-TRICARE (877-874-2273) for assistance.

The following services require prior authorization. This list is not all inclusive and additional prior authorization requirements may apply.

- Adjunctive dental care
- Behavioral health care services
- All non-emergency 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

Civilian Prior Authorization Requests

Network providers can request prior authorizations from Health Net online, by fax or by telephone. Network providers who have Internet access are encouraged to use the Online Authorization and Referral Submission Tool at www.hnfs.com to submit authorization requests electronically. Providers can track the status of their prior authorization request via the Referral and Authorization Status Tool, which is located at www.hnfs.com.

If faxing a request, network providers will need to complete the TRICARE Service Request/Notification form. To access the form, go to www.hnfs.com. A sample completed form and detailed instructions are available on the site. To prevent processing delays, remember these important guidelines when completing and faxing the form:
• If filling out the form by hand, be sure to write legibly.
• 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).
• In order to help Health Net to process the request in a timely fashion, be sure to complete every section of the form, including clinical history/previous treatment and supporting test results.

Once the form is complete, fax it to 888-299-4181 (outpatient) or 877-809-8667 (inpatient). Do not include a fax cover sheet.

Fax each patient request separately.

To prioritize prior authorization requests, network providers should follow the guidelines listed in Figure 6.2.

### Prioritizing Prior Authorization Requests

| When the care is required within 24 hours: | ・Do not send a fax or submit the request online 
▪ Call Health Net for a telephone request at 877-TRICARE (877-874-2273)  
▪ Choose the option for “authorizations and referrals”  
▪ Clearly state that the prior authorization is urgent when speaking with the Health Net representative |
| --- | --- |
| When the care is required within 72 hours: | ・Online—Submit the request using the Online Authorization and Referral Submission Tool at [www.hnfs.com](http://www.hnfs.com). Select “URGENT” when submitting your request.  
▪ By fax—Fax a completed TRICARE Service Request/Notification form without a cover sheet to 888-299-4181 (outpatient) or 877-809-8667 (inpatient). Write the word “URGENT” in large capital letters at the top to identify the need for expedited processing. |
| When requesting a routine prior authorization¹: | ・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.hnfs.com](http://www.hnfs.com)  
▪ By fax—Fax a completed TRICARE Service Request/Notification form without a cover sheet to 888-299-4181 (outpatient) or 877-809-8667 (inpatient) |

¹Routine prior authorizations relate to care needed within the four-week TRICARE specialty care access standards. Nearly all requests are considered “routine” requests, unless care is required in less than 72 hours.

Health Net will contact the provider’s office for further information or clarification, if necessary. If your office is not equipped with Internet access or a fax machine, request a prior authorization from Health Net by calling 877-TRICARE (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 also receive a referral confirmation notice 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 notification letter will include an authorization number for the approved service(s) or will provide guidance on how to appeal a denied authorization.

For inpatient services, the notification letter will include a tracking number when for the prior authorization request once Health Net is notified of the admission.

The medical facility will receive an authorization number after Health Net receives a medical review and discharge date information. To expedite claims payment, network providers should submit the authorization number with
their TRICARE claim. See the “Claims Processing and Billing Information” section for tips on submitting claims with prior authorization numbers.

- Schedule the Service(s)—Assist the beneficiary with scheduling the requested services.

**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 877-809-8667. See the Important Provider Information section in this handbook for more information.

**Referrals and Authorizations and Other Health Insurance**

When a beneficiary has “other insurance” (OHI) that provides primary coverage, prior authorization requirements will not apply. Any medically necessary reviews when TRICARE becomes secondary payer will be performed on a retrospective basis.

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

- Adjunctive dental care
- Behavioral health care services
- All non-emergency 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

**Military Treatment Facility Provider Prior Authorization Requests**

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

**Additional Referral/Prior Authorization Requests from Specialists**

Specialists can make requests directly to Health Net for additional visits or services beyond the initial authorization. There must be an “active” or already-approved referral or prior authorization in place for a specialist to request additional visits or services.

**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:

- Use the Online Authorization and Referral Submission Tool or fax a TRICARE Service Request/Notification form to Health Net at 888-299-4181 (outpatient) or 877-809-8667 (inpatient)
- Provide Health Net with the patient’s original, assigned referral or authorization number
- Convey 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
- The appointed representative of an appropriate appealing party
- A custodial parent of a minor beneficiary is considered the “appointed representative” until the beneficiary reaches 18 years of age (21 years of age for Pennsylvania residents). After coming of age, the beneficiary must submit the appeal on his or her own behalf or appoint a representative (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 him or her in the TRICARE appeal.
- An MTF provider or other employee of the United States Government is not a proper appealing party and, due to conflict of interest, may not be appointed as a representative (except a government employee or uniformed services member who represents an immediate family member).
- 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 Representative for Appeals form. The form is available on www.hnfs.com. This form must be completed in its entirety and submitted with the appeal request.

The following guidelines apply when requesting 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 in the instructions for requesting 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 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 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 not yet been rendered and has been denied because it is
not medically necessary or denied based on coverage limitations contained in 32 CFR 199 and the TRICARE Policy Manual. A non-expedited reconsideration appeal must be filed within 90 calendar days of the date of the denial letter.

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

| Online | Health Net website at www.hnfs.com — use the online Request for Appeal form |
| Fax    | Health Net confidential fax at 888-881-3622 |
| Mail   | Health Net Federal Services, LLC TRICARE North Authorization Appeals PO Box 105087 Atlanta, GA 30348-5087 |

**ADSM Reconsiderations**

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

**Providing Care to Beneficiaries from Other Regions**

**Emergency Care**

For emergency care, TRICARE never requires referrals and authorizations, regardless of where beneficiaries receive care. However, to avoid penalties or denial of a claim, providers must notify the appropriate regional contractor (Health Net for North Region, TriWest for West Region and Humana Military for South Region—see contact information in The Welcome to TRICARE and the North Region section of this handbook).

TRICARE Prime beneficiaries are instructed to contact their PCM within 24 hours of an inpatient admission, or the next business day, to coordinate ongoing care.

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

**Urgent Care**

For urgent care, TRICARE Prime beneficiaries must receive referrals from their PCMs or regional contractors. **Please note:**

- If a TRICARE Prime beneficiary does not receive a referral, the claim will be paid under the POS option.
- If you provide emergency or urgent care services to a TRICARE beneficiary from a different region, the beneficiary will be responsible for paying the applicable copayment or cost-share, and you will submit claims to the region in which the beneficiary is enrolled, not the region in which he or she received care.

See the Claims Processing and Billing Information section of this handbook for more information.

**Routine Care**

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

- TRICARE Standard beneficiaries will pay applicable cost-shares, and providers will submit claims to the region where the beneficiary resides, not the region in which he or she received care.
- TRICARE Prime beneficiaries will receive a referral from their PCMs or regional contractors for out-of-region care and will pay applicable cost-shares. Providers will submit claims to the region where the beneficiary is enrolled, not the region in which he or she received care. If a TRICARE Prime beneficiary does not receive a referral for out-of-region care, claims will be paid under the POS option. See the Claims Processing and Billing Information section for more information.
If you have questions about processing claims for beneficiaries from other regions, contact Health Net at 877-TRICARE (877-874-2273).

Medical Records Documentation

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

- **Patient identification**—Each page of the chart must include a unique identifier, which may include the patient’s identification number, medical record number and first and last name.

- **Individual records**—Each patient must have his or her own record. If information for different family members is kept in the same folder, each patient must have his or her own separate and individual section.

- **Personal data**—Information must include name, address, date of birth, sex and home, work or contact phone number, as well as emergency contact information. For children, the parent’s home or work phone number or any number where parents can be reached is sufficient. For adults, the phone number of a friend or relative, or any number where a contact may be reached and/or a message left is sufficient.

- **Allergies**—Each record must have an allergy notation in a prominent and consistent place. If a patient has no allergies, this must be noted. “NKDA,” “NKA,” and “O” are all acceptable notations.

- **Chronic/significant problem list**—A separate list of all the patient’s chronic/significant problems must be maintained. A chronic problem is defined as one that is of long duration, slow progression or shows little change.

- **Chronic/continuing medication list**—These should be listed on a medication sheet and updated as necessary with dosage changes and the date the change was made. All medications taken on an ongoing basis—both prescribed and over-the-counter—must be noted on the medication list. The drug, dose, route, duration and quantity of all prescribed medications must be noted. A separate medication sheet is recommended, but a physician may also choose to write out all current medications at each visit. Ongoing medications that have been discontinued since the last visit should be noted on the medication sheet.

- **Immunization history**—A history of all immunizations must be documented.

- **Chart legibility**—Charts must be legible to someone other than the writer. A record that is deemed illegible by the reviewer should be evaluated by a second person.

- **Informed consent**—Physicians must document their instructions to the patient regarding any suggested invasive procedure, making notation of the alternatives to the proposed procedure, any risk involved in the procedures and the patient’s understanding and agreement to the planned procedure. An invasive procedure is defined as surgical entry into tissues, cavities or organs, or repair of major traumatic injuries associated with an operating, delivery, emergency room or outpatient setting, including physician offices.

- **Provider signature/name, each entry**—An individualized, legible identification of the author, including his or her title, must follow each entry into the medical record, whether the entry is handwritten or dictated.

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

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

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

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

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

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

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

• **Diagnosis/impression for chief complaint**—The diagnosis identified during each visit should be documented.

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

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

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

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

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

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

• **Preventive health education**—This refers to health teaching provided to the member appropriate for age and lifestyle.

### Utilization Management

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

#### Prospective Review

Prospective review is the process of reviewing and assessing health care services before they are rendered. Prospective review procedures allow for benefit determination, evaluation of proposed treatment, determination of medical or psychological necessity, assessment of level of care required, assignments of expected length of stay for those types of care and for facilities not reimbursed on a diagnosis-related group (DRG) basis and appropriate placement prior to the delivery of care. Failure to comply with timeline standards for notification and prior authorization will result in payment reduction.
Health Net will query the Defense Enrollment Eligibility Reporting System (DEERS) to determine beneficiary eligibility and coordinate MTF access. 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:

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

Additionally, mandatory prior authorization requirements for selected services will be applied for elective admissions. Refer to the Prior Authorization, Referral and Benefit Tool at www.hnfs.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 care’s medical necessity for those who are admitted to their facilities and who have not received a precertification for services. This typically includes beneficiaries who have been admitted urgently or for emergencies, or who have not received a prior authorization for services.

Prior authorization for inpatient care (medical/surgical), as well as behavioral health care, is required for ADSMs, TRICARE Prime beneficiaries, and TPRADFM beneficiaries. For TRICARE Standard, TRICARE Reserve Select, TRICARE Retired Reserve and OHI beneficiaries, only behavioral health care services require prior authorization for inpatient care.

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

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

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

**Concurrent Review**

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

When prospective review (prior authorization) is initiated, Health Net will secure the necessary medical information to support the medical, surgical or behavioral health care services. Medical necessity
and appropriateness of setting and treatment review is performed by the UM staff with each concurrent review utilizing InterQual 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 illness decreases in severity and/or begins to stabilize, the intensity of services will reflect that. If care may be delivered in a less emergency-oriented setting, the medical management staff will coordinate efforts with the physician directing the care (and the patient and family members) to facilitate timely and appropriate discharge. Health Net will initiate discharge planning for all admissions during the first review of the case.

**Transitional Care Program**

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

**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 at-risk beneficiaries who require extensive, complex and/or costly services to the most appropriate levels of care necessary for effective treatment. By linking many services, including the MTF and TRICARE regional resources, the case manager can coordinate treatment to provide cost-effective, quality care.

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

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 the patient.

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, Health Net makes a referral 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 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 105423
Atlanta, GA 30348-5423
Fax: 888-299-4181

Please visit [www.hnfs.com](http://www.hnfs.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**

The Warrior Care Support (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. To ensure total health care support, each program participant is assigned a specific health care coordinator, who personally guides the patient through the care continuum, ensuring seamless transitions throughout the various stages of health care and military status changes.

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

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

Any uniformed 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 network provider referrals or authorizations.

If you are caring for an ADSM with significant health care challenges, please call [877-TRICARE (877-874-2273)](tel:+18778742273) 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 the TRICARE Quality Monitoring Contract manager (TQMC).

Medical records will be reviewed to:

- Assess the accuracy of information provided during the prospective review process
- Determine the medical or psychological necessity and quality of care provided
- Validate the review determinations made by the utilization review staff
- Determine whether the diagnostic and procedural information and/or discharge status of the patient as reported on the hospital and/or professional provider’s claim matches the attending physician’s description of care and services documented in the medical record
All cases selected for focused retrospective review will undergo the following review activities:

- **Admission review**—The medical record must indicate that the inpatient hospital care was medically or psychologically necessary and provided at the appropriate level of care.
- **Invasive procedure review**—The performance of unnecessary procedures may represent a quality and/or utilization problem. The medical record must support the medical necessity of the procedure performed. Invasive procedures are defined as all surgical and any other procedures that affect DRG assignment.
- **Discharge review**—Records will be reviewed using appropriate criteria (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.
- **TQMC**—Keystone Peer Review Organization, Inc., (KēPRO) of Harrisburg, PA, is the TRICARE Quality Monitoring Contract (TQMC) manager and will assist DoD, Health Affairs, TMA, MTF market managers and the TROs by providing the government with an independent, impartial evaluation of the care provided to beneficiaries within the Military Health System. The TQMC will review care provided by Health Net network providers in addition to other TRICARE contractors and subcontractors on a limited basis. The TQMC is part of TRICARE’s Quality and Utilization Review PRO program, in accordance with 32 CFR 199.15.
- **An Important Message from TRICARE**—TRICARE policy requires that every patient admitted to a hospital receive and sign the document that details beneficiary rights concerning coverage and payment of his or her hospital stay and post-hospital services. To access this document, go to Health Net’s website at www.hnfs.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.hnfs.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 payment requirements.
- **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 incomplete or unsubmitted records are subject to technical denial for the requested dates of stay, and Health Net may recoup claims payment.

All records requested by Health Net in support of UM, case management, and clinical quality management (CQM) activities must also be submitted within 10 calendar days, but are not subject to reimbursement compensation.
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 coverage or service denial
• Special concern and attention should be paid to underutilization risk

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

Clinical Quality Management

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

The CQM program is designed to identify and analyze issues and, when needed, to implement timely and appropriate corrective action. The program achieves this by reviewing potential quality issues/patient safety issues, resolving beneficiary and provider grievances and performing clinical quality review studies. Peer review and compliance with professionally recognized standards form the basis of the potential quality issues/patient safety investigation process. Periodic reassessments assure that improvements remain effective.

Corrective action may include, but is not limited to:

• Provider notification (by oral or written contact) and education (e.g., through required further training)
• Provider recertification for procedures or services or in-service training for staff

• Submission of a corrective action plan for review and follow-up monitoring
• Administrative policies and procedure revision as appropriate
• Prospective or retrospective trend analysis of practice patterns
• Intensified review of practitioners or facilities, including, but not limited to, requirements for second opinions for procedures, retrospective or prospective review of medical records, claims, or requests for prior authorization
• Modification, suspension, restriction or termination of participation privileges

Credentialing and Certification

Health Net and MHN conduct an initial credentials review on each potential network provider to determine if the provider meets the minimum criteria. All providers that wish to contract with Health Net or MHN are required to complete an application form and participate in an extensive review of qualifications, education, licensure, malpractice coverage, etc. Health Net retains the right to deny or terminate any provider who does not meet or no longer meets Health Net, MHN, TRICARE or Utilization Review Accreditation Commission standards.

Additionally, Health Net and MHN conduct a full recredentialing review of health care providers every three years to help maintain current, accurate files and to ensure that all providers meet the credentialing 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. To make this change, you may need additional education or training documentation if it was not verified or requested during the previous credentialing process. Please select the credentialing option at 877-TRICARE (877-874-2273) for the appropriate forms, information 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

Note: 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 health care professional licenses that are currently revoked, suspended or ineligible to be licensed in any jurisdiction

- Maintain professional liability insurance with limits of liability compliant with 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®

Note: 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 Exclusively for Primary Care Managers

- Provide 24-hour medical coverage

- Agree to refer TRICARE beneficiaries for specialty care, when necessary

- Have a valid TIN for the applicable practice site(s)

Delegated Credentials/Subcontracted Provider Functions

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

- Network provider’s credentialing plan and policies and procedures meet Health Net’s reasonable standards, guidelines and any required national accrediting standards.

- 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 provider contracts.

- Current and future professional providers that join the provider network must be properly credentialled and re-credentialled 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 credentialled by him or her.

- 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 recredentialing process, including, but not limited to, records related to the credentialing of all current or future professional providers (professional provider records).

• Annually, or upon reasonable request, 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 recredentialing reports that identify those professional providers credentialled/recredentialled, the effective date of such actions, the most recent prior date of credentialing/recredentialing 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.

• Health Net must be notified by network provider of any material change in performing 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 subdelegate any delegated functions to another organization, network provider must request Health Net’s prior approval in a written request. No subdelegation may occur prior to Health Net’s review and written approval. At Health Net’s sole discretion, it may approve or deny any requested subdelegation. If Health Net approves any subdelegate, then any subdelegated 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 subdelegate.

• 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 postpayment 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 to, 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 in any state or U.S. territory 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 to the general public, such as by commercial insurance carriers or other federal health benefit entitlement programs
- Failure to maintain adequate clinical or financial records
- A pattern of claims for services that are not medically necessary or, if necessary, not to the extent rendered
- A pattern of waiver of beneficiary (patient) 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 practices can be considered fraudulent and abusive. Fraudulent actions can result in criminal or civil penalties.

Fraudulent or abusive activities may result in administrative sanctions, including suspension or termination as a TRICARE-authorized provider. The TMA Office of General Counsel works in conjunction with the Program Integrity Branch to deal with fraud and abuse. The DoD Inspector General and other agencies investigate TRICARE fraud.

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

- Who committed the fraud
- When the fraud occurred (time frame)
- Where the fraud occurred
- Detailed description of the fraudulent activity

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:

<table>
<thead>
<tr>
<th>Phone</th>
<th>Health Net Fraud and Abuse Hotline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>800-977-6761</td>
</tr>
<tr>
<td>E-mail</td>
<td><a href="mailto:Program.Integrity@healthnet.com">Program.Integrity@healthnet.com</a></td>
</tr>
<tr>
<td>Online</td>
<td><a href="http://www.hnfs.com">www.hnfs.com</a></td>
</tr>
<tr>
<td>Mail</td>
<td>Health Net Federal Services, LLC</td>
</tr>
<tr>
<td></td>
<td>ATTN: Program Integrity</td>
</tr>
<tr>
<td></td>
<td>PO Box 105310</td>
</tr>
<tr>
<td></td>
<td>Atlanta, GA 30348-5310</td>
</tr>
</tbody>
</table>

**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.

Grievances are generally resolved within 60 days of receipt. Following resolution of a grievance, the grievant/aggrieved party will be notified of the review completion.

**Who May File a Grievance?**

Any TRICARE beneficiary, sponsor, parent or guardian of an eligible dependent child, or other representative

Any TRICARE civilian or military provider.
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 staffs
- The performance of any part of the health care delivery system, including Health Net staff
- Practices related to patient safety

Required Information for Grievances

Beneficiary-submitted grievances must include:

- 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 HNFS Grievance form. To download either of these forms, visit www.hnfs.com.

Submitting a Grievance Form

Submit a HNFS Grievance form or a letter outlining the grievance information previously listed in one of the following ways:

<table>
<thead>
<tr>
<th>Method</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax</td>
<td>888-317-6155</td>
</tr>
<tr>
<td>Mail</td>
<td>Health Net Federal Services, LLC</td>
</tr>
<tr>
<td></td>
<td>ATTN: Grievances</td>
</tr>
<tr>
<td></td>
<td>PO Box 105338</td>
</tr>
<tr>
<td></td>
<td>Atlanta, GA 30348-5338</td>
</tr>
<tr>
<td>Online</td>
<td><a href="http://www.hnfs.com">www.hnfs.com</a></td>
</tr>
</tbody>
</table>
North Region Claims Processor

**PGBA, LLC**

PGBA, LLC (PGBA) is the Health Net partner for claims processing in the TRICARE North Region. Health Net’s and PGBA’s websites offer many online claims customer service features, including eligibility, claim status and electronic claims submission.

TRICARE network providers must file TRICARE claims with Health Net/PGBA, even when a patient has other health insurance (OHI). All network providers must file claims electronically.

Non-network providers are encouraged to take advantage of the electronic claims and EFT features available through Health Net and PGBA. For more information, visit Health Net at [www.hnfs.com](http://www.hnfs.com) and PGBA at [www.myTRICARE.com](http://www.myTRICARE.com).

**Claims-Processing Standards and Guidelines**

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

- TRICARE network providers must file all claims electronically (see “Electronic Claim Submission” below) within 90 days of the date care was provided.
- Where TRICARE is the secondary payer, 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 must use their 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).

**HIPAA National Provider Identifier Compliance**

TRICARE requires claims to be filed electronically with the appropriate Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant standard electronic claims format. If a non-network provider must submit claims on paper, TRICARE requires them to be submitted on either a CMS-1500 (professional charges) or a UB-04 (institutional charges) claim form.

All covered entities must use their National Provider Identifiers (NPIs) on HIPAA standard electronic transactions in accordance with the Implementation Guide. When filing claims with NPI(s), billing NPIs are always required. When applicable, rendering provider NPIs are also required. Providers treating TRICARE beneficiaries referred by another provider should also obtain the referring provider’s NPI and include it on transactions, if available. See the “Important Provider Information” section of this handbook for additional details on HIPAA NPI compliance.

**Important Billing Tips**

There are several reasons why claims are delayed or denied unnecessarily. Here are some helpful billing tips to help facilitate prompt claim payments. Industry standard modifiers and condition codes may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply when billing.

- **Provider identification number and address**—All claims must include the provider’s federal Tax Identification Number (TIN) 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. On the UB-04 institutional claim form, enter the physical address of the
facility in the Form Locator (FL) 1 field and enter the pay-to address in the FL 2 field. The facility's federal TIN is entered in the FL 5 field.

- **NPIs**—Include all applicable NPIs. TRICARE providers should already have NPIs. If you do not have an NPI, complete the online National Plan & Provider Enumeration System application at [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do) or download a paper application of the National Provider Identifier (NPI) Application/Update form at [www.cms.hhs.gov/cmsforms/downloads/cms10114.pdf](https://www.cms.hhs.gov/cmsforms/downloads/cms10114.pdf).

- **Provider signature**—Always include the provider’s signature or use a signature stamp in Box 31 of the CMS-1500 claim form. The signature stamp must be on file with Health Net/ PGBA. “Signature on File” is an acceptable signature on electronic claims only. Because the provider’s signature block FL was eliminated from the UB-04 institutional claim, the National Uniform Billing Committee has designated FL 80 (Remarks) as the location for the provider signature if signature-on-file requirements do not apply to the claim.

  **Note:** All non-network claims must have a provider’s signature or an acceptable facsimile, in accordance with the *TRICARE Operations Manual*, Chapter 8, Section 4. If a non-network claim does not contain an acceptable signature, the claim will be returned.

- **Demographic Changes**—You must inform Health Net if any changes occur in professional affiliation, TIN, office location or telephone number. Visit [www.hnfs.com](https://www.hnfs.com) or call 877-TRICARE (877-874-2273) to update your information. Additionally, Health Net will contact network providers periodically to verify provider demographic information, if they are accepting new patients and their ability to meet office appointment and access standards.

- **Prior authorization**—Certain services require a prior authorization from Health Net.

  **Note:** Provider claims submitted for services rendered without 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 extend authorization and ensure correct claims payment.

- **XPressClaim®**—XPressClaim is a fast, easy and free real-time, online claims processing system available through the Health Net website at [www.hnfs.com](https://www.hnfs.com) and the PGBA website at [www.myTRICARE.com](https://www.myTRICARE.com). You can reconcile claims payments, check claim status and check OHI information using tools on these websites. See “Electronic Claims Submission” later in this section for more information.

- **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 websites [www.hnfs.com](https://www.hnfs.com) and [www.myTRICARE.com](https://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 website at [www.hnfs.com](https://www.hnfs.com) or the PGBA website at [www.myTRICARE.com](https://www.myTRICARE.com), or by calling 877-TRICARE (877-874-2273) and accessing the interactive voice response (IVR) system.

- **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. Alternatively, 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.” The beneficiary’s signature is not required. Also include the TRICARE sponsor’s Social Security number (SSN) in Box 1 of the CMS-1500 claim form or FL 60 of the UB-04 claim form.

- **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 that charges are itemized correctly.

• **Place of service codes**—Use the correct Place of Service codes. (see Box 24B of the CMS-1500 claim form).

• **OHI**—Always ask the patient if he or she has OHI. It is your responsibility to submit OHI benefit information in Boxes 4, 9, 11 and 29 on the CMS-1500 claim form or FL 34, 50, 54 and 58 of the UB-04 claim form, or submit an EOB statement from the OHI carrier along with the TRICARE claim if submitting a paper claim. For EDI billing instructions, please visit www.myTRICARE.com.

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

• **Unlisted or unspecified Current Procedural Technology (CPT®) codes**—When submitting a paper claim and billing with an unlisted or unspecified CPT procedure code, you must include supporting documentation describing the services rendered or the claim will be returned for this information. For electronic claims, include the codes; PGBA will request additional information from you when applicable.

• **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, code services 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 Life**—For beneficiaries who are eligible for Medicare and TRICARE For Life, submit Medicare claims first. Claims will automatically be transmitted from Medicare to TRICARE for secondary claims processing, and Wisconsin Physicians Service (WPS) will process the TRICARE portion of the claim. Refer to “Claims for Beneficiaries Using Medicare and TRICARE” later in this section for more information.

• **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 applicable HCPCS code and the applicable National Drug Code printed on the manufacturer’s drug packaging label in Column 24D of the CMS-1500 claim form. Ensure that the appropriate units are indicated in Column 24G of the CMS-1500 claim form.

• **Active duty service member (ADSM) claims**—Send TRICARE Prime Remote (TPR) and Supplemental Health Care Program (SHCP) claims to PGBA for processing and payment. There are no copayments, cost-shares or deductibles for ADSMs.

**Note:** ADSM claims will be paid at the same negotiated rate as stated in your contracted agreement. There are no copayments, cost-shares or deductibles for ADSMs or active duty family members (ADMFs) enrolled in TPR. For ADMFs, the copayment, cost-share and deductible waiver does not apply to pharmacy copayments, the TRICARE Extended Care Health...
Option cost-shares or point of service (POS) cost-shares and deductibles. The same balance billing limitations applicable to TRICARE apply to the Supplemental Health Care Program (SHCP). For more information regarding balance billing, see the Important Provider Information section of this handbook.

- **Anesthesia Claims**—Claim submissions must include the five-digit CPT-4 anesthesia code, start and stop times and the appropriate anesthesia modifier. Claims submitted with surgical codes will be denied.

### Avoid Duplicate Claims

Duplicate claims are caused when providers resubmit claims that have already been processed through to completion. In many instances, duplicate claims have been previously processed for payment. In other situations, claims have been processed for partial payment or possibly denied.

To avoid submitting duplicate claims, providers should reconcile their financial records as soon as possible to avoid the impression of an unpaid balance.

Duplicate claims add unnecessary processing costs that must be paid by the government, not to mention the additional administrative costs to your practice. Keeping unnecessary health care costs low is a responsibility of all members of the health care community.

- Check your TRICARE claims status online to verify completed, in process/pending, returned or transferred claims
- Reconcile your accounts receivables by viewing your TRICARE remits online
- Sign up for electronic funds transfer (EFT) to receive your TRICARE payments faster
- Ensure your provider demographic information on file is accurate
- Wait at least 30 days before claims resubmission or phone inquiry
- Reconcile financial records punctually to avoid the impression of an unpaid balance
- Submit complete claims

If, after reconciling your accounts, you determine that payment has not been received or you disagree with the payment, **do not resubmit the same claim**. Instead, explain your circumstance or disagreement by submitting written correspondence to:

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

### Electronic Claims Submission

Electronic claims submission allows you to submit claims directly to Health Net/PGBA, ensuring faster processing and reduced paperwork. Network providers are required to submit all claims electronically. 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.

- **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 **877-EDI-CLAIM (877-334-2524)** or visit [www.myTRICARE.com](http://www.myTRICARE.com).

### XPressClaim Online Claims Processing System

XPressClaim offers a secure Internet-based, real-time, online claim-processing system to transmit TRICARE claims 24 hours a day, seven days a week. XPressClaim is free, requires no additional hardware or software, accepts CMS-1500 and UB-04 claims, will adjudicate most TRICARE claims upon submission and provides a clear explanation of what TRICARE allows and what the patient owes. XPressClaim uses a sophisticated encryption technology to transmit claims securely. The system fully protects the confidentiality of patient records and complies with HIPAA rules and regulations.
Registered members of myTRICARE Secure for Providers can sign up for XPressClaim by accessing the registration portal and creating a unique username and password. You and other office staff can register instantly for both myTRICARE Secure for Providers and XPressClaim at www.myTRICARE.com.

After registration, XPressClaim will preload patient information for your TRICARE patients from claims that have been processed within the past 12 months. To enter a new patient’s information, you need the TRICARE sponsor’s SSN and the patient’s date of birth. You can use XPressClaim to reconcile claim payments and check a TRICARE patient’s claim status, eligibility and OHI information.

XPressClaim can also handle claims submission for groups with multiple locations and multiple providers. To file claims, you will need the following:

- Dates of service
- Standard ICD-9 diagnosis and CPT-4 procedure codes
- Basic data related to the diagnosis

Note: You can submit up to 49 lines of information on one XPressClaim.

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**

You can sign up for electronic funds transfer (EFT) at www.myTRICARE.com. You must have signature authority, which means you are authorized to disburse funds, sign checks, add, modify or remove bank account information.

Visit www.myTRICARE.com, and select “Provider,” then the North Region, which takes you to the North Region Provider welcome page. Select the “Electronic Claims Filing” tab, then “Electronic Funds Transfer (EFT)” and follow the steps to sign up.

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**Claims Submission Addresses**

Figure 7.1 provides a listing of addresses related to claim submission for professional, institutional, ancillary and behavioral health care providers.

**North Region Submission Addresses**

**Figure 7.1**

<table>
<thead>
<tr>
<th>Claims Submission</th>
<th>Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Correspondence (Auth to Disclose Form)</td>
<td>Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870141 Surfside Beach, SC 29587-9741</td>
</tr>
<tr>
<td>Non-Network and Network Provider Reconsideration of Claims under the Administrative Review Process</td>
<td>Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE Administrative Reviews P.O. Box 105266 Atlanta, GA 30348-5266</td>
</tr>
<tr>
<td>TRICARE Prime Remote (TPR) Claims</td>
<td>Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870162 Surfside Beach, SC 29587-9762</td>
</tr>
</tbody>
</table>
Hospital and Facility Billing

- **Emergency room charges** in conjunction with a diagnosis-related group (DRG), reimbursed hospital stay must be billed on a separate outpatient UB-04. Additionally, Revenue Code 490 (ambulatory surgery room charge) cannot be submitted on an inpatient claim and should be billed as a separate outpatient service on the UB-04.

- **Interim claims** for DRG-based facilities (regardless of the type of contract with Health Net) are accepted when the patient has been in the hospital at least 60 days. If you submit multiple claims on one patient’s behalf, you must submit them in chronological order. Fixed-dollar parameters do not apply.

- **Hospital-based ambulatory surgical procedures** are reimbursed under the TRICARE Outpatient Prospective Payment System (OPPS) for hospitals that are subject to this reimbursement methodology. 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. For OPPS-exempt facilities, ambulatory surgery procedures falling on the TRICARE Management Activity (TMA) Addendum are reimbursed at specified rates. To ensure proper payment for procedures not listed on the TMA Ambulatory Surgery Center (ASC) Addendum (located at www.tricare.mil), make sure that ICD-9 surgical procedure codes have a corresponding CPT-4 code and a charge for each CPT-4 code billed.

- **Certain surgical procedures** normally reimbursed at a hospital-based surgery center can also be reimbursed at a freestanding ASC. TRICARE network providers must contact Health Net to obtain prior authorization for appropriate procedures performed at an ASC. Refer to the TRICARE Policy Manual, Chapter 11, Section 6.2 at http://manuals.tricare.osd.mil for more information.

Proper Treatment and Observation Room Billing

**Revenue Code 076x**

Determining when to use revenue code 076x (treatment) to indicate use of a treatment room can be confusing, and improper coding can lead to inappropriate billing.

Under OPPS, 0510- and 0760-series revenue codes are reimbursed based on the HCPCS codes submitted on the claim.

You may indicate revenue code 076x for the actual use of a treatment room in which a specific procedure has been performed or a treatment rendered. Revenue code 076x may be appropriate for charges for minor procedures and in the following instances:

- 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 (observation room) is the only revenue code that should be used for observation billing. Non-OPPS outpatient observation stays may be reimbursed for a maximum of 48 hours.

Billing with V Codes

Health Net and PGBA remind you that it is especially important to use the proper diagnosis codes that begin with the letter “V” (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:** V-code diagnoses for TRICARE behavioral health care services are not covered. TRICARE policy defines V-code diagnoses as “conditions not attributable to a mental disorder.”
How to Bill with V Codes

Be sure to use the correct V-code diagnosis to indicate the reason for the patient’s visit. The V code must match the CPT code to indicate a given procedure’s correlation to the V-code diagnosis. V codes correspond to descriptive, generic, preventive, ancillary or required medical services and should be billed accordingly. This section covers different types of V codes and their uses.

**Descriptive V Codes**

For V codes that provide descriptive information as the reason for the patient visit, you may designate that description as the primary diagnosis. An example of a descriptive V code is a routine infant or child health visit, which is designated as V20.2.

**Generic V Codes**

For lab, radiology, pre-op or similar services, do not use a generic V code as a primary diagnosis. Rather, the underlying medical condition should be listed as the primary diagnosis for these ancillary services.

**Preventive V Codes**

For preventive services, a V code that describes a personal or family history of a medical condition is sufficient as a primary diagnosis without the need for additional diagnostic information. Examples are a mammography, a Pap smear or a fecal occult blood screening.

Figure 7.2 lists clinical preventive care services and the corresponding V codes.

---

**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>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>V76.51</td>
<td>Individuals at average risk for colon cancer:</td>
</tr>
<tr>
<td></td>
<td>V16.0</td>
<td>• Colonoscopy covered once every 10 years beginning at age 50.</td>
</tr>
<tr>
<td></td>
<td>V12.72</td>
<td>Increase risk:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Due to hereditary non-polyposis colorectal cancer syndrome—Every two years beginning at age 25, or five years younger than earliest age of diagnosis in affected relative, whichever is earlier, and then annually after age 40.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Due to familial risk of sporadic colorectal cancer—For first-degree relatives with sporadic colorectal cancer or adenoma before age 60, or with multiple first-degree relatives with colorectal cancer or adenomas, a colonoscopy should be performed every three to five years, beginning 10 years earlier than the youngest affected relative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individuals at high risk for colon cancer:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Colonoscopy once every one to two years for individuals with a genetic or clinical diagnosis of hereditary non-polyposis colorectal cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20 to 25 or 10 years younger than the earliest age of diagnosis, whichever is earlier.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For individuals diagnosed with inflammatory bowel disease (IBD), chronic ulcerative colitis (CUC), or Crohn’s disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• There is no copayment or cost-share required for TRICARE Prime, TRICARE Standard and TRICARE Extra beneficiaries.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
</tbody>
</table>
## 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>
| **Mammograms**          | V76.11 V76.12 V10.3 | - Performed once per 12 month period for women beginning at age 40 (baseline at age 35 for high risk, then annually thereafter).  
- 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. |
| **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).  
- TRICARE Prime Remote 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 (ADFM):**  
- 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 during routine exams 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 between the ages of 3 and 6 years under the well-child benefit (use V20.2).  
**Diabetic Patients:**  
- Routine eye exams for diabetic patients are not limited, however, one exam per year is recommended.  
- Diabetic patients at any age are allowed one routine eye examination each calendar year.  
**Note:** For TRICARE Prime beneficiaries, 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. |
| **Pap Smear**           | V72.3 V76.2 | - One per 12 month period for women starting at the age of 18 (younger, if sexually active). No PCM or Health Net referral or copayments are required for TRICARE Prime beneficiaries, but they must use network providers. |

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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.
## 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>
<tbody>
<tr>
<td>Proctosigmoidoscopy/Sigmoidoscopy</td>
<td>V76.41 V76.51 V16.0 V12.72</td>
<td><strong>Individuals at average risk for colon cancer:</strong>&lt;br&gt;• Proctosigmoidoscopy/sigmoidoscopy once every three to five years beginning at age 50</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Individuals at increased risk for colon cancer:</strong>&lt;br&gt;• Proctosigmoidoscopy/sigmoidoscopy once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Individuals at high risk for colon cancer:</strong>&lt;br&gt;• Annual flexible sigmoidoscopy, beginning at age 10 through 12, for individuals with known or suspected familial adenomatous polyposis</td>
</tr>
<tr>
<td>Regular Immunizations</td>
<td>V20.2 (includes well-child check)</td>
<td>• 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 <a href="http://www.cdc.gov">www.cdc.gov</a>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> Immunizations required for ADFMs whose sponsors have permanent change-of-station orders to overseas locations are also covered. You must include a copy of the sponsor’s change-of-station orders when filing the claim. TRICARE does not cover immunizations for personal overseas travel.</td>
</tr>
<tr>
<td>School Physical (Note: Sports-related physical exams are not a covered benefit.)</td>
<td>V70.0 V70.3 V70.5 V70.9</td>
<td>• TRICARE-eligible dependents who are at least 5 years old and less than 12 years old may get physical exams that are required by schools in connection with enrollment as students in those schools. This benefit does not include physical exams that may be required by the school to participate in school sports. Physicals for children ages 12 and older are authorized only if the physical is required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• TRICARE Prime beneficiaries do not have copayments, but they must use network providers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• TRICARE Standard and TRICARE Extra beneficiaries will pay the applicable cost-shares and deductibles.</td>
</tr>
<tr>
<td>Well-Child Visits (birth to 6 years)</td>
<td>V20.2</td>
<td>• Includes routine newborn care, comprehensive health promotion and disease prevention exams, vision and hearing screenings, height/weight/head circumference, routine immunizations (according to CDC guidelines) and developmental/behavioral appraisals (according to American Academy of Pediatrics®).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• There is no copayment or cost-share required for TRICARE Prime, TRICARE Standard and TRICARE Extra beneficiaries.</td>
</tr>
</tbody>
</table>

### Allergy Testing and Treatment Claims

TRICARE does not cover certain types of allergy tests. Prior to performing 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.

Pending medical review and approval, a limited number of replacement antigen sets are payable. Bill with the appropriate CPT code per replacement antigen set quantity (e.g., one vial, two or more vials).
Global Maternity Claims

Global maternity involves the billing process for maternity-related beneficiary claims. After confirming that a patient is pregnant, all charges related to the pregnancy are grouped under one global maternity diagnosis code. When billing, list the appropriate pregnancy diagnosis code as the primary diagnosis. Figure 7.3 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 beneficiaries are referred for specialty obstetric care, the PCM submits a service request notification to Health Net.

Professional and technical components of medically necessary fetal ultrasounds are covered outside of the maternity global fee. The medically necessary indications include, but are not limited to, clinical circumstances that require obstetric ultrasounds to estimate gestational age, evaluate fetal growth, conduct a biophysical evaluation for fetal well-being, evaluate a suspected ectopic pregnancy, define the cause of vaginal bleeding, diagnose or evaluate multiple gestations, confirm cardiac activity, evaluate maternal pelvic masses or uterine abnormalities, evaluate suspected hydatidiform mole and evaluate fetus condition in late registrants for prenatal care.

Maternal Serum Alpha Fetoprotein and Multiple Marker Screen Test are cost-shared separately (outside of the global fee) as part of the maternity care benefit to predict fetal developmental abnormalities or genetic defects. A second phenylketonuria test for infants is allowed if administered one to two weeks after discharge from the hospital as recommended by the American Academy of Pediatrics®.

Claims for Mutually Exclusive Procedures

Mutually exclusive procedures are two or more procedures that are usually not performed during the same patient encounter on the same date of service. Generally, there is significant overlapping of services and duplication of effort with mutually exclusive procedures. Mutual exclusivity rules may also include different procedure code descriptions for the same type of procedure although only one procedure code applies. For example, vaginal hysterectomy and abdominal hysterectomy are considered mutually exclusive.

Physician-Administered Drug and Vaccine Claim Filing

The National Drug Code (NDC) number, drug quantity and package unit indicators are necessary on drug and vaccine claim filings when no nationally established Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) maximum allowable charge (CMAC) pricing has been set. Visit [www.tricare.mil/cmac](http://www.tricare.mil/cmac) to determine if a CMAC exists for specific drugs or vaccines.

EDI claims provide the fields for keying the NDC, drug quantity and the package or unit indicator. This is in addition to the HCPCS/CPT drug code and quantity, which can be different from the NDC drug quantity. Where necessary, provide supporting documentation, such as the certificate of medical necessity (CMN), medical records, or NDC information. For assistance with EDI claims call the EDI Help Desk (electronic claims) at 877-334-2524.

CMS-1500 hard-copy claims must use the shaded space above each line in the “Lines” field. These shaded areas are for additional information. The 11-digit NDC number (with no spaces or dashes), the drug quantity based on the NDC, and the “P” or “U” indicator should go in the shaded area. The actual line below the shaded area should include the appropriate HCPCS/CPT drug code, and the quantity based on the code must also be included in the “Lines” field. Again, if supporting documentation (such as CMN, medical records, or NDC information) is needed, please include it with the submission of the paper claim.
Processing Claims for Out-of-Region Care

If you provide health care services to a TRICARE beneficiary who resides in or is enrolled in a different region, the beneficiary will pay the applicable cost-share, and you will submit reports and claims information to the region based on the TRICARE beneficiary's enrollment address, not the region in which he or she received care. If you have a claim issue or question regarding a TRICARE patient who normally receives care in another TRICARE region, call the appropriate region-specific number for assistance.

South Region—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—888-TRIWEST (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 a TRICARE Prime-like benefit, USFHP is a separately funded program that is distinct from the TRICARE program administered by Health Net. The designated provider is responsible for all medical care for a USFHP beneficiary, including pharmacy services, primary care and specialty care.

If you provide care to a USFHP beneficiary outside of the network or in an emergency situation, you must file claims with the appropriate designated provider at one of the addresses listed in Figure 7.4. Do not file USFHP claims with Health Net or PGBA.

For more information about the USFHP, visit www.usfamilyhealthplan.org.

USFHP Designated Providers

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martin's Point Health Care</td>
<td>P.O. Box 11410, Portland, ME 04104-5040</td>
</tr>
<tr>
<td>Brighton Marine Health Center</td>
<td>P.O. Box 9195, Watertown, MA 02471-9195</td>
</tr>
<tr>
<td>US Family Health Plan at SVCMC</td>
<td>P.O. Box 830745, Birmingham, AL 35283-0745</td>
</tr>
<tr>
<td>Johns Hopkins Medical Services Corporation</td>
<td>6704 Curtis Court, Glen Burnie, MD 21060</td>
</tr>
<tr>
<td>CHRISTUS Health US Family Health Plan</td>
<td>ATTN: Claims P.O. Box 924708, Houston, TX 77292-4708</td>
</tr>
<tr>
<td>Pacific Medical Clinics</td>
<td>1200 12th Avenue South, Quarters 8 &amp; 9 Seattle, WA 98144-2790</td>
</tr>
</tbody>
</table>

TRICARE Overseas/Foreign Claims

WPS is the claims processor for the TRICARE Overseas Program (TOP), TOP-Prime and TOP-Prime Remote all overseas claims. If filing a claim for an ADSM who is enrolled in a TOP option (TOP Prime, TOP Prime Remote, or TOP Standard), submit it to the address listed in Figure 7.5. If filing a claim for a non-ADSM who is enrolled in a TOP option, refer to the addresses listed in Figure 7.6.

Overseas claims for National Guard and Reserve members on orders of 30 days or less should be sent to WPS. To expedite claims, the provider should submit a copy of the member’s orders with the claim. The orders verify the member’s eligibility for TRICARE benefits.
TRICARE Overseas Claims Contact Information—Active Duty Service Members

<table>
<thead>
<tr>
<th>All Overseas Areas</th>
<th>TRICARE Overseas ADSM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 7968</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707-7968</td>
</tr>
<tr>
<td></td>
<td>Hotline: 877-451-8659</td>
</tr>
<tr>
<td></td>
<td>Fax: 215-773-2701</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.tricare-overseas.com">www.tricare-overseas.com</a></td>
</tr>
</tbody>
</table>

TRICARE Overseas Claims Contact Information—Non-Active Duty Service Members

<table>
<thead>
<tr>
<th>TRICARE Eurasia-Africa (Africa, Europe, and the Middle East)</th>
<th>TRICARE Overseas Region 13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 8976</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707-8976</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRICARE Latin America and Canada (Canada, the Caribbean basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands)</th>
<th>TRICARE Overseas Region 15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 7985</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707-7985</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRICARE Pacific (Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries)</th>
<th>TRICARE Overseas Region 15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 7985</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707-7985</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRICARE Puerto Rico and Virgin Islands</th>
<th>TRICARE Overseas Region 15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 7985</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707-7985</td>
</tr>
</tbody>
</table>

Claims for Beneficiaries Using Medicare and TRICARE

WPS is the claims processor for all TRICARE For Life (TFL) claims. If you currently submit claims to Medicare on your patient’s behalf, you will not need to submit a claim to WPS. WPS has signed agreements with each Medicare carrier allowing direct, electronic transfer of TRICARE beneficiary claims to WPS. Claims processed by Medicare are submitted electronically to WPS/TFL. Beneficiaries and providers will receive an EOB from WPS/TFL after processing.

Note: Participating providers accept Medicare’s payment amount. Nonparticipating providers do not accept Medicare’s payment amount and are permitted to charge up to 115 percent of the Medicare-approved amount. Both participating and nonparticipating providers may bill Medicare.

When TRICARE is the primary payer, all TRICARE requirements apply. Refer to the TRICARE Reimbursement Manual, Chapter 4, at http://manuals.tricare.osd.mil for details.

Figure 7.7 contains important contact information for you and your patients regarding Medicare and TRICARE claims.

Medicare and TRICARE Claims Contact Information

<table>
<thead>
<tr>
<th>Appeals</th>
<th>WPS/TRICARE For Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTN: Appeals</td>
<td>P.O. Box 7490</td>
</tr>
<tr>
<td>Madison, WI 53707-7490</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claims Submission (Note: Submit claims to Medicare first.)</th>
<th>WPS/TRICARE For Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTN: Claims Submission</td>
<td>P.O. Box 7890</td>
</tr>
<tr>
<td>Madison, WI 53707-7890</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Customer Service</th>
<th>WPS/TRICARE For Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTN: Customer Service</td>
<td>P.O. Box 7889</td>
</tr>
<tr>
<td>Madison, WI 53707-7889</td>
<td></td>
</tr>
</tbody>
</table>

| Online | www.TRICARE4u.com |

<table>
<thead>
<tr>
<th>Program Integrity</th>
<th>WPS/TRICARE For Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTN: Program Integrity</td>
<td>P.O. Box 7516</td>
</tr>
<tr>
<td>Madison, WI 53707-7516</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Refunds</th>
<th>WPS/TRICARE For Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTN: Refunds</td>
<td>P.O. Box 7928</td>
</tr>
<tr>
<td>Madison, WI 53707-7928</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Third-Party Liability</th>
<th>WPS/TRICARE For Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTN: TPL</td>
<td>P.O. Box 7897</td>
</tr>
<tr>
<td>Madison, WI 53707-7897</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Toll-Free Telephone</th>
<th>866-773-0404</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toll-Free TDD</td>
<td>866-773-0405</td>
</tr>
</tbody>
</table>
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 guests of the U.S. Government. They receive the same benefits as American ADSMs, including no out-of-pocket expenses for care directed by the military treatment facility (MTF). Eligible accompanying family members can receive 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 MTF referrals prior to receiving outpatient services from network providers. NATO family members follow the same prior authorization requirements as TRICARE Standard and TRICARE Extra beneficiaries, and 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. To download a copy of the Request for Non-Covered Services form, go to www.hnfs.com.

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. To be reimbursed for inpatient services, have the NATO beneficiary make the appropriate arrangements with the NATO national embassy or consulate in advance.

NATO beneficiary eligibility is now maintained in the Defense Enrollment Eligibility Reporting System (DEERS). Claims submission procedures are the same as for U.S. ADFMs in the United States.

Claims for 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>800-733-8387</th>
</tr>
</thead>
</table>
| Mail      | VA Health Administration Center CHAMPVA  
P.O. Box 469063  
Denver, CO 80246-9063 |
| Website   | www.va.gov/hac/forproviders |

Claims for current treatment must be filed within 365 days of the date of service. Providers may file health care claims electronically on behalf of their patients. If you wish to file a paper health care claim, download CHAMPVA claim forms from the CHAMPVA website, and file them within the one-year claim-filing deadline. Send the claim to:

VA Health Administration Center CHAMPVA  
P.O. Box 469064  
Denver, CO 80246-9064

You may submit a written appeal if exceptional circumstances prevent you from filing a claim in a timely fashion. Send written appeals to:

VA Health Administration Center CHAMPVA  
ATTN: Appeals  
P.O. Box 460948  
Denver, CO 80246-0948

Note: Do not send appeals to the claims-processing address. This will delay your appeal.

If your CHAMPVA claim is misdirected to PGBA, PGBA will forward CHAMPVA claims to the CHAMPVA VA Health Administration Center in Denver, Colorado, within 72 hours of identifying the CHAMPVA claim. A letter will be sent to the claimant informing him or her of the transfer. The letter includes instructions on how to submit future CHAMPVA claims and to direct any correspondence for CHAMPVA beneficiaries to the CHAMPVA VA Health Administration Center.
Claims for the Continued Health Care Benefit Program

Humana Military 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. Health Net does not administer this program. CHCBP beneficiaries may request that providers file medical claims on their behalf. For questions and assistance regarding CHCBP claims, call PGBA at 800-403-3950.

Filing claims correctly ensures timely and accurate payment. File CHCBP claims electronically at www.myTRICARE.com. File all paper claims at one of the addresses listed in Figure 7.8.

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 and the ECHO Autism Demonstration Project must have a valid written authorization.

All claims for ECHO-authorized care (including ECHO Home Health Care and the Autism Demonstration Project) 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.

Refer to the TRICARE Policy Manual, Chapter 9, Section18.1 and the TRICARE Operations Manual, Chapter 18, Section 9 at http://manuals.tricare.osd.mil for additional claims information.

Claims for TRICARE Reserve Select and TRICARE Retired Reserve

All individuals covered under TRICARE Reserve Select (TRS) should follow the applicable cost-shares, deductibles, and catastrophic caps for TRICARE Standard- and TRICARE Extra-covered ADFMs. TRICARE Retired Reserve (TRR) coverage is similar to TRICARE Standard and TRICARE Extra for retirees.

TRICARE Network Providers

- File claims with PGBA electronically on behalf of TRS and TRR members just as you would file other TRICARE claims.
- Submit claims through the Health Net at www.hnfs.com and PGBA www.myTRICARE.com websites.
- The cost-share for all TRS members, including National Guard and Reserve members, is 15 percent of the negotiated fee for covered services from TRICARE network providers. TRICARE will reimburse the remaining amount of the negotiated fee.
- The cost-share for all TRR members, including Retired National Guard and Reserve members, is 20 percent of the negotiated fee for covered services from TRICARE network providers. TRICARE will reimburse the remaining amount of the negotiated fee.

Non-Network TRICARE- Authorized Providers

- Participation with TRICARE (e.g., accepting assignment, filing claims, and accepting the TRICARE-allowable charge as payment in full) is encouraged, but not required, on TRS and TRR claims.
• Non-network providers are encouraged to submit their TRICARE claims electronically.
• The cost-share for all TRS-covered members is 20 percent of the TRICARE-allowable charge for covered services from non-network TRICARE-authorized providers. TRICARE will reimburse the remainder of the TRICARE-allowable charge.
• The cost-share for all TRR-covered members is 25 percent of the TRICARE-allowable charge for covered services from network TRICARE-authorized providers. TRICARE will reimburse the remainder of the TRICARE-allowable charge.
• Members will file their own reimbursement claims with TRICARE and then pay the non-network provider, if a non-network provider does not participate on a particular claim.

Note (for non-network providers): By federal law, if a non-network provider does not participate on a particular claim, the provider may not charge TRS or TRR members more than 15 percent above the TRICARE-allowable charge. This amount is the same as it is for ADFMs.

The TRICARE-allowable charge schedules can be found at www.tricare.mil/cmac.

Supplemental Health Care Program Claims

Supplemental Health Care Program (SHCP) covers any health care service as long as the MTF refers the patient or the military service point of contact (SPOC) authorizes the care. Claims for the SHCP are processed and paid through Health Net/PGBA.

Supplemental Health Care Program claims must be submitted electronically or mailed to the address below:

Health Net Federal Services, LLC
c/o PGBA, LLC/TRICARE
P.O. Box 870140
Surfside Beach, SC 29587-9740

The same balance billing limitations applicable to TRICARE apply to the SHCP. For more information regarding balance billing, see the Important Provider Information section of this handbook.

TRICARE and Other Health Insurance

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 7.9.

OHI: Services Requiring TRICARE Prior Authorization  Figure 7.9

• Adjunctive dental care
• Dental anesthesia and institutional dental services
• Behavioral health care services
• All non-emergency inpatient admissions for substance use disorders 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

• TRICARE pays after a beneficiary’s other health insurance (OHI), including Medicare, employment-based coverage and other insurance policies and plans.
• If the OHI denies a claim because the beneficiary did not follow the OHI’s rules, TRICARE will also not pay.
• If services are denied by the patient’s OHI on the basis that the care is not medically necessary, TRICARE benefits can only be considered after all avenues of appeal available with the OHI have been pursued.

TRICARE may become the primary payer if OHI benefits are exhausted or if the primary OHI does not cover a service or supply. If TRICARE becomes the primary payer, additional prior authorization requirements may apply.
Health Net must have current OHI information to process claims appropriately. It is the beneficiary's responsibility to notify Health Net of any changes. Beneficiaries may print, complete and mail the TRICARE Other Health Insurance Questionnaire form if there are any changes to OHI coverage. Mail the completed form(s) to:

Health Net Federal Services
TRICARE North - OHI Questionnaires
PO Box 870159
Surfside Beach, SC 29587-9759

It is also very important to ensure providers have accurate information regarding other health insurance and TRICARE coverage. Incorrect information submitted by a provider could cause unnecessary delays or denials.

When a TRICARE-eligible beneficiary has OHI, submit a claim using the following guidelines:

| Identify other health insurance (OHI) in the Claim Form | To identify OHI in the claim form:
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mark “Yes” in Box 11 (CMS-1500) or FL (UB-04)</td>
<td>Indicate the primary payer in Box 9 (CMS-1500) or FL 50 (UB-04).</td>
</tr>
<tr>
<td>• Indicate the amount paid by the OHI in Box 29 (CMS-1500) or FL 54 (UB-04).</td>
<td>Indicate insured's name in Box 4 (CMS-1500) or FL 58 (UB-04).</td>
</tr>
<tr>
<td>• Indicate the allowed amount of the OHI in FL 39 (UB04) using value code 44 and entering the dollar amount.</td>
<td></td>
</tr>
</tbody>
</table>

| Payment Guidelines | • If TRICARE is the secondary payer, submit the claim to the primary payer first. If the claim processor’s records indicate that the beneficiary has one or more primary insurance policies, submit explanation of benefit (EOB) information from other insurers along with the TRICARE claim. |
|-------------------|• Health Net/PGBA will coordinate benefits when a claim has all of the necessary information (e.g., billed charges, beneficiary's copayment and OHI payment). In order for Health Net/PGBA to coordinate benefits, the EOB must reflect the patient's liability (copayment and/or cost-share), the original billed amount, the allowed amount, and/or any discounts. If the EOB indicates that a primary carrier has denied a claim due to failure to follow plan guidelines or utilize network providers, TRICARE will also deny the claim. |

| Payment Guidelines | TRICARE does not always pay the beneficiary’s copayment or the balance remaining after the OHI payment. However, the beneficiary liability is usually eliminated. The beneficiary should not be charged the cost-share when the TRICARE EOB shows no patient responsibility. Payment calculations differ by provider status as detailed below. |
|-------------------|With TRICARE network providers and non-network providers that accept TRICARE assignment, TRICARE pays the lesser of:
| • The billed amount minus the OHI payment | • The amount TRICARE would have paid without OHI |
| • The beneficiary's liability (OHI copayment, cost-share, deductible, etc.) |  |
| With non-network providers that do not accept TRICARE assignment, providers may only bill the beneficiary up to 115 percent of the TRICARE-allowable charge. If the OHI paid more than 115 percent of the allowed amount, no TRICARE payment is authorized, the charge is considered paid in full, and the provider may not bill the beneficiary. If the service is not covered by TRICARE, the beneficiary may be liable for these charges. |
**Payment Guidelines**

With all other providers, TRICARE pays the lesser of:
1. 115 percent of the allowed amount minus the OHI payment
2. The amount TRICARE would have paid without OHI
3. The beneficiary’s liability (OHI copayment, cost-share, deductible, etc.)

When working with OHI, all TRICARE providers should keep in mind:
- TRICARE will not pay more as a secondary payer than it would have as a primary payer.
- Point of service cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. However, the beneficiary must have prior authorization for certain covered services (listed in Figure 8.10), regardless of whether or not he or she has OHI.

In some cases, the TRICARE Summary Payment Voucher/Remit will state, “Payment reduced due to OHI payment,” and there may be no payment and no beneficiary liability. The TRICARE cost-share (the amount of cost-share that would have been taken in the absence of primary insurance) is indicated on the TRICARE Summary Payment Voucher/Remit only to document the amount credited to the beneficiary’s catastrophic cap.

**Note:** For EDI claims, visit [www.MyTRICARE.com](http://www.MyTRICARE.com).

## TRICARE and Third-Party Liability Insurance

The Federal Medical Care Recovery Act allows the government to be reimbursed for costs associated with treating a TRICARE beneficiary who has been injured in an accident caused by someone else.

When a claim appears to have possible third-party involvement, certain necessary actions can affect total processing time. 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 8.10), regardless of the billed amount, and claims for professional services that exceed a TRICARE liability of $500, which indicate an accidental injury or illness, will be flagged for research. Claims will not be processed further until the beneficiary completes and submits a *Statement of Personal Injury—Possible Third Party Liability (DD Form 2527)*.

**DD Form 2527** is available on the Health Net website at [www.hnfs.com](http://www.hnfs.com).

There are certain diagnosis codes that are exceptions. A *DD Form 2527* is not required for certain diagnosis codes, specifically those listed in Figure 7.10.

### Diagnosis Codes

**Exceptions/Exclusions**  
**Figure 7.10**

- 910.2–910.7
- 911.2–911.7
- 912.2–912.7
- 913.2–913.7
- 914.2–914.7
- 915.2–915.7
- 916.2–916.7
- 917.2–917.7
- 918.0
- 918.2
- 919.2–919.7

When a claim is received that appears to have possible third-party involvement, the following process will occur:

- The *DD Form 2527* will be mailed to the beneficiary.
- The claim is suspended for up to 35 calendar days, during which time the beneficiary is expected to complete and return the form.
- If the *DD Form 2527* is not received within 35 calendar days, the claim will be denied and “Requested third-party liability information not received” will appear on the EOB.
- The claim will be reprocessed when the *DD Form 2527* is completed and returned by the beneficiary. Encourage the beneficiary to fill out, sign, and return the form within the 35 calendar days to avoid payment delays.
- If the illness or injury was not caused by a third party, but the diagnosis code(s) falls between 800 and 999, the beneficiary is still responsible for filling out, signing and returning *DD Form 2527*. If the form is not returned, the claim will be denied and you may bill the beneficiary.
If you believe a patient needs to complete the DD Form 2527 based on the information above, it is appropriate to have copies of the form on hand for the patient to complete. Taking this precautionary step can help expedite the claim-submission process and ensure timely reimbursement. The DD Form 2527 is available at www.hnfs.com.

Fax completed forms to 888-432-7077 or send 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 is pending, visit www.myTRICARE.com to check the status of the claim. Also, you may request a review in writing.

Network providers are to accept the TRICARE-allowable amount as payment in full for covered services. Refer to the “Important Provider Information” section of this handbook for additional information about provider and beneficiary payment responsibilities.

Beneficiaries are responsible for their out-of-pocket expenses reflected on the TRICARE Summary Payment Voucher/Remit, including deductible, cost-share and/or copayment amounts.

TRICARE’s Debt Collection Assistance Officer Program

Debt Collection Assistance Officers (DCAOs) are located at each TRICARE Regional Office and MTF to assist TRICARE beneficiaries with collection-related issues. The DCAO cannot provide beneficiaries with legal advice or fix their credit ratings, but DCAOs can help beneficiaries through the debt collection process by providing documentation for the collection or credit-reporting agency in explaining the circumstances relating to the debt. The DCAO directory is available online at www.tricare.mil/dcao.

When meeting with a DCAO, beneficiaries must take or submit documentation (e.g., debt collection letters, EOBs, and medical/dental bills from providers) associated with a collection action or adverse credit rating. The more information the beneficiary provides, the less time it will take to determine the cause of his or her problem. The DCAO will research the beneficiary’s claim with the appropriate claims processor or other agency points of contact and provide the beneficiary with a written resolution to the collection problem. The DCAO will notify the collection agency that action is being taken to resolve the issue.

TRICARE Claim Disputes

In the event you disagree with reimbursement rates, TRICARE has a claims review process.

The following subsections detail the appropriate types of review requests, time frames for submitting requests, contact information, and the information to include with requests. By following the rules and timelines for requesting reviews, you can help promptly resolve your request.

Claims Adjustments and Allowable Charge Reviews

An allowable charge review can be requested by a provider or beneficiary if either party disagrees with the reimbursement allowed on a claim. This includes “By Report” or unlisted procedures where a provider can request a review.
The following issues are considered reviewable:
- Allowable charge complaints
- Charges denied as “included in a paid service”
- Keying errors/corrected bills
- Eligibility denials/patient not in DEERS
- Cost-share and deductible inquiries/disputes
- Claims denied because the provider is not a TRICARE-authorized provider
- ClaimCheck® denials (except assistant surgeons)
- OHI denials/issues
- Prescription drug coverage
- Third-party liability denials/issues
- Claims denied or payments reduced due to no authorization
- Point of service when reason for dispute is other than emergency care
- Claims denied because they were filed late
- Charges denied as a duplicate charge
- Claims denied as “requested information was not received”
- Coding issues
- Claims denied because non-availability statement is not in DEERS
- Network provider disputes relating to contractual reimbursement amount

If requesting an allowable charge review, you must submit the following information:
- A copy of the claim and the TRICARE EOB or TRICARE summary payment voucher/remit
- Supporting medical records and any new information that was not originally submitted with the claim

**Note:** Requests must be postmarked or received within 90 calendar days of the date of the TRICARE Summary Payment Voucher/Remit. Mail all correspondence to:

**Health Net Federal Services, LLC**
c/o PGBA, LLC/TRICARE
Allowable Charge Reviews/Claims Adjustments
P.O. Box 870141
Surfside Beach, SC 29587-9741

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**Network Provider Disputes Relating to Contractual Reimbursement Amount**

Network providers who believe they have been reimbursed at less than the agreed-upon rate should file a request for review to:

**TRICARE North Region**
P.O. Box 870141
Surfside, Beach, SC 29587-9741

Submit the request for review within 90 calendar days of the date of the TRICARE EOB or TRICARE Summary Payment Voucher/Remit relating to the alleged underpayment. The request should identify, in detail, why you believe the reimbursement amount is incorrect. Failure to submit a request for review within these parameters and within this time frame constitutes a waiver of any such claim.

**Appeals and Administrative Reviews of Claim Denials**

The following are considered appealable issues:
- Claims denied because the service is not covered under TRICARE or exceeds policy limitations/coverage criteria
- Claims denied as not medically necessary
- Claims for assistant surgeon charges denied by ClaimCheck
- Claims processed as POS only when the reason for dispute is that the service was for emergency care

**Note:** Network providers must hold the beneficiary harmless for non-covered care. Under the “hold harmless” policy, the beneficiary has no financial liability and, therefore, has no appeal rights. However, if the beneficiary has waived his or her hold harmless rights, the beneficiary may be financially liable and further appeal rights may be offered. Refer to the “Informing Beneficiaries about Non-Covered Services” and “TRICARE’s Hold Harmless Policy” section in the Important Provider Information chapter of this handbook.
Appeal and administrative review requests must be postmarked or received within 90 calendar days of the date of the denial. For TRICARE purposes, a postmark is a cancellation mark issued by the U.S. Postal Service. If the postmark on the envelope is not legible, the date of receipt is deemed to be the date of the filing.

Providers may mail appeal and review requests to:

Health Net Federal Services, LLC
c/o PGBA, LLC/TRICARE Claims Appeal
P.O. Box 105266
Atlanta, GA 30348-5266

After your request is submitted, Health Net will notify you of the outcome in writing or by telephone. For more detailed information about the appeals process, visit Health Net’s website at www.hnfs.com.

When filing appeals, keep in mind the following:

- All appeal/administrative review requests must be in writing and must be signed
- All appeal/administrative review requests must state the issue in dispute
- Be certain to include a copy of the initial denial (EOB/provider remittance advice) and any additional documentation in support of the appeal.

Additionally, provide the following information with your appeal:

- Sponsor’s SSN
- Beneficiary’s/patient’s name
- Date(s) of service
- Provider’s address, telephone/fax numbers and e-mail address, if available
- Statement of the facts of the request

Appeals must be requested by an appropriate appealing party. Persons or providers who may appeal are limited to:

- TRICARE beneficiaries (including minors)
- Participating, non-network, TRICARE-authorized providers
- A custodial parent or guardian of a minor beneficiary
- A provider denied approval as a TRICARE-authorized provider
- A provider who has been terminated, excluded or suspended
- A representative appointed by a proper appealing party. Examples of representatives are:
  - Parents of a minor*
  - An attorney
  - A network provider
  - Administrative reviews must be requested by the network provider.

* If your patient is a minor, his or her custodial parent is presumed to have been appointed his or her representative in the appeal.
TRICARE Reimbursement Methodologies

Reimbursement rates and methodologies are subject to change per the Department of Defense (DoD) guidelines. Refer to the TRICARE Reimbursement Manual at http://manuals.tricare.osd.mil for more details.

Reimbursement Limit

Payments made to network providers for medical services rendered to TRICARE beneficiaries will not exceed 100 percent of the TRICARE-allowable charges. All reimbursement methodologies discussed in this chapter are impacted by a network provider’s negotiated discount rate. A provider will not receive 100% of the TRICARE allowable charge if they have a negotiated discount.

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 website at www.tricare.mil/cmac. Periodic CMAC changes apply to both network and non-network providers.

Site-of-Service Pricing Categories

TRICARE CMAC changes vary at the discretion of the TRICARE Management Activity (TMA). The following four categories represent the four categories of providers used for reimbursement.

1. Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons and audiologists provided in a facility including hospitals (both inpatient and outpatient and billed with the appropriate revenue and procedure code for the outpatient department where the services were rendered), residential treatment centers (RTCs), ambulances, hospices, military treatment facilities (MTFs), psychiatric facilities, community mental health centers (CMHCs), skilled nursing facilities (SNFs), ambulatory surgical centers (ASCs), etc.

2. Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons and audiologists provided in a non-facility including provider offices, home settings and all other non-facility settings. The non-facility CMAC rate applies to occupational therapy (OT), physical therapy (PT) or speech therapy (ST) regardless of the setting.

3. Services, of all other providers not found in Category 1, provided in a facility including hospitals (both inpatient and outpatient and billed with the appropriate revenue code for the outpatient department where the services were rendered), RTCs, ambulances, hospices, MTFs, psychiatric facilities, CMHCs, SNFs, ASCs, etc.

4. Services, of all other providers not found in Category 2, provided in a non-facility including provider offices, home settings and all other non-facility settings.
**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 TRICARE-allowable charge for a service is $90, and 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 Ambulatory Payment Classifications (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. In lieu of a specific exception, prevailing profiles are developed on:

- A statewide basis (localities within states are not used, nor are prevailing profiles developed for any area larger than individual states)
- A non-specialty basis

Prevailing profiles are developed using a minimum of eight claims submitted for reimbursement to TRICARE. All actual charges billed for the service are put in ascending order, and the lowest charge (in the array) that is high enough to include 80 percent of the cumulative charges (number of claims billed) becomes the prevailing charge. For more details, refer to the TRICARE Reimbursement Manual, Chapter 5, Section 1, at 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 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 details, refer to the TRICARE Reimbursement Manual, Chapter 5, Section 1, at http://manuals.tricare.osd.mil.

If TRICARE does not receive eight claims for a particular procedure, TRICARE will determine the prevailing rate by using information about the volume of business done by various providers or suppliers within the TRICARE North Region or through available price lists and supply catalogs.
Anesthesia Claims and Reimbursement

Professional anesthesia claims must be submitted on a Centers for Medicare & Medicaid Services (CMS)-1500 form, using the applicable CPT anesthesia codes. If applicable, bill the claim with the appropriate physical status (P) modifier and, if appropriate, other optional modifiers. An anesthesia claim must specify who provided the anesthesia. In cases where a portion of the anesthesia service is provided by an anesthesiologist and a nurse anesthetist performs the remainder, the claim must identify exactly which provider performed each service, and may include modifiers to make this distinction.

Anesthesia Rates

TRICARE calculates anesthesia reimbursement rates using the number of time units, the Medicare relative value units (RVUs), and the anesthesia conversion factor.

Calculating Anesthesia Reimbursement

The following formula is used to calculate the TRICARE anesthesia reimbursement:

\[(\text{Time Units} + \text{RVUs}) \times \text{Conversion Factor}\]

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 beneficiary's presence). A base unit includes reimbursement for:

- Preoperative examination of the beneficiary
- Administration of fluids and/or blood products incident to the anesthesia care
- Interpretation of 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

Services not included in the base value include: placement of arterial, central venous and pulmonary artery catheters and the use of transesophageal echocardiography. When multiple surgeries are performed, only the RVUs for the primary surgical procedure are considered, while the time units should include the entire surgical session.

Note: This does not apply to continuous epidural analgesia.

Time Unit—Time units are measured in 15-minute increments, and any fraction of a unit is considered a whole unit. Anesthesia time starts when the anesthesiologist begins to prepare the beneficiary for anesthesia care in the operating room or in an equivalent area. It ends when the anesthesiologist is no longer in personal attendance and the beneficiary may be safely placed under post-anesthesia supervision. On the CMS-1500 the DUTs in column 24G should always be 1 unit per procedure. Please indicate the start and stop times of the anesthesia administration on the CMS-1500. For EDI claims, please indicate the total anesthesia minutes in loop and segment 2400/SV104.

Conversion Factor—The sum of the time units and RVUs is multiplied by a conversion factor. Conversion factors differ between physician and non-physician providers and vary by state, based on local wage indexes.

For more specific information on anesthesia reimbursement calculation and methodologies, refer to the TRICARE Reimbursement Manual 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

Only non-OPPS providers are reimbursed under this methodology. Hospital-based surgery procedures are reimbursed under OPPS (for hospitals that are subject to OPPS).

Ambulatory surgery facility payments fall into one of 11 TRICARE grouper rates. All procedures identified by TMA for reimbursement under this methodology can be found in the TRICARE Reimbursement Manual, Chapter 9, Section 1, at http://manuals.tricare.osd.mil. TRICARE payment rates established under this system apply only to the facility charges for ambulatory surgery.

Ambulatory surgery providers may view reimbursements, ambulatory surgery rates and grouper assignments at www.tricare.mil/ambulatory.

Ambulatory Surgery Center Charges

All hospitals or freestanding ambulatory surgery centers (ASCs) must submit claims for surgery procedures on a UB-04 claim form. Hospital-based ASC providers must use Type of Bill (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. Providers will not be reimbursed for incidental procedures. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure. Incidental procedures will only be reimbursed if required for surgical management of multiple traumas or if involving a major body system different from the one served by the primary surgery.

For freestanding ASCs and non-OPPS hospitals, in some instances of multiple ambulatory surgeries, one procedure may be on TRICARE Management Activity 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 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.

Note: There are specific procedures that may not discount even if billed as a multiple surgery session. See “CPT4 Procedural Coding Manual” under “modifier 51 exempt” or “add on” codes.

Ambulatory Surgery Rate Lookup Tool

To find ambulatory surgery rates, go to www.tricare.mil/ambulatory and follow the online prompts.
Diagnosis-Related Group Reimbursement

DRG reimbursement is a reimbursement system for inpatient charges from facilities. This system assigns payment levels to each DRG based on the average cost of treating all TRICARE beneficiaries in a given DRG. The TRICARE DRG-based payment system is modeled on the Medicare inpatient prospective payment system (PPS). A grouper program classifies each case into the appropriate DRG.

The grouper used for the TRICARE DRG-based payment system is the same as the Medicare grouper with some modifications, such as neonate DRGs. Refer to the TRICARE Reimbursement Manual at http://manuals.tricare.osd.mil for more details.

TRICARE uses the TRICARE Severity DRG payment system, which is modeled on the Medical Severity DRG payment system.

Present On Admission Indicator

Inpatient acute care hospitals that are paid under the TRICARE DRG-based payment system are required to report a present on admission (POA) indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered as POA. Any hospital-acquired conditions, as identified by Medicare, will not be reimbursed. A list of hospital-acquired conditions can be found at www.tricare.mil/drgrates.

Any claim that does not report a valid POA indicator for each diagnosis on the claim will be denied. The five valid POA codes are described in Figure 8.1.

<table>
<thead>
<tr>
<th>POA Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Indicates that the condition was present on admission.</td>
</tr>
<tr>
<td>W</td>
<td>Affirms that the provider has determined based on data and clinical judgment that it is not possible to document when the onset of the condition occurred.</td>
</tr>
<tr>
<td>N</td>
<td>Indicates that the condition was not present on admission.</td>
</tr>
<tr>
<td>U</td>
<td>Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.</td>
</tr>
<tr>
<td>1</td>
<td>Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines.</td>
</tr>
</tbody>
</table>

The following hospitals are exempt from POA reporting for TRICARE:
- Critical access hospitals (CAHs)
- Long term care hospitals
- Cancer hospitals
- Children’s inpatient hospitals
- Inpatient rehabilitation hospitals
- Psychiatric hospitals and psychiatric units
- Sole community hospitals (SCHs)
- Department of Veterans Affairs hospitals

Diagnosis-Related Group Calculator

The DRG calculator is available at 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.

Submit requests for reimbursement under capital and direct medical education costs to Health Net/PGBA, LLC (PGBA) on or before the last day of the 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.

When submitting initial requests for capital and direct medical education reimbursement, providers should report the following:

- Hospital name
- Hospital address
- Hospital Tax Identification number
- Hospital Medicare provider number
- Time period covered (must correspond with the hospital’s Medicare cost-reporting period)
- Total inpatient days provided to all beneficiaries in units subject to DRG-based payment
- Total TRICARE inpatient days, provided in “allowed” units, subject to DRG-based payment (excluding non-medically necessary inpatient days)
- Total inpatient days provided to active duty service members in units subject to DRG-based payment
- Total allowable capital costs (must correspond with the applicable pages from the Medicare cost report)
- Total allowable direct medical education costs (must correspond with the applicable pages from the Medicare cost report)
- Total full-time equivalents for residents and interns
- Total inpatient beds as of the end of the cost-reporting period
- Title of official signing the report
- Reporting date

The provider’s officer (or administrator) must include a statement certifying that any changes resulting from a Medicare audit will be reported to Health Net/PGBA within 30 days of the hospital’s notification of the change. A failure to promptly submit an amended Medicare cost report is considered a misrepresentation of the cost report information, and can be considered fraudulent.

Bonus Payments in Health Professional Shortage Areas

Network and non-network physicians (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 care providers who are eligible for HPSA bonuses are M.D.s and D.O.s. Non-physicians (Ph.D.s, social workers, counselors, certified psychiatric nurse specialist and marriage and family therapists) are not eligible.

Providers can determine if they are in an HPSA by accessing the U.S. Department of Health and Human Services, Health Resources and Services Administration’s HPSA search tool at http://hpsafind.hrsa.gov. The Centers for Medicare and Medicaid Services (CMS) has HPSA designations along with bonus payment information at www.cms.hhs.gov/HPSAPSAPhysicianBonuses.

How Bonus Payments Are Calculated

For providers who are eligible and located in an HPSA, Health Net’s claims processor, PGBA, will calculate a quarterly 10 percent bonus payment from the total paid amount for TRICARE Prime, TRICARE Prime Remote, 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 claims.
Please keep in mind the following:

- When submitting a claim for bonus payment, providers must include the AQ CPT modifier in Column 24D of the CMS-1500 claim form.
- For CPT codes with multiple modifiers, place the AQ modifier last.
- If you are eligible for a bonus payment but do not submit claims with the appropriate modifier, you will not receive the bonus payment from TRICARE. There are no retroactive payments, adjustments or appeals for obtaining a bonus payment, so be sure to include the bonus payment modifier with your initial claims submission if you are eligible.
- When calculating bonus payment for services that contain both a professional and technical component, only the professional component will be used.

**Note:** Although Medicare no longer requires the use of modifiers, TRICARE still requires their use. If you submit claims without the modifier, you cannot receive a bonus payment.

### Skilled Nursing Facility Pricing

Skilled nursing facilities (SNFs) are paid using the Medicare PPS and consolidated billing. Skilled nursing facility PPS rates cover all routine, ancillary and capital costs of covered SNF services. SNFs are required to perform resident assessments using the minimum data set. Skilled nursing facility admissions require an authorization when TRICARE is the primary payer.

SNF admissions for children under age 10 and critical access hospital swing beds are exempt from skilled nursing facility PPS and are reimbursed based on DRG or contracted rates.

For more information about skilled nursing facility PPS, refer to the TRICARE Reimbursement Manual, Chapter 8, Section 2 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 must be renewed every 60 days. To receive private duty nursing or additional nursing services/shift nursing, the TRICARE beneficiary may be enrolled in an alternative TMA-approved special program and a case manager must manage his or her progress.

### Tips for Filing a Request for Anticipated Payment

To file a request for anticipated payment (RAP):

- The bill type in Form Locator (FL) 4 of the UB-04 is always 322 or 332.
- The “To” date and the “From” date in FL 6 must be the same and must match the date in FL 45.
- FL 39 must contain code 61 and the Core-Based Statistical Area code of the beneficiary’s residence address.
- There must be only one line on the RAP, and it must contain revenue code 023 and 0 dollars. On this line, FL 44 must contain the Health Insurance PPS code. The quantity in FL 46 must be 0 or 1.
- FL 63 must contain the authorization code assigned by the Outcome Assessment Information Set.

### Tips for a Final Claim

- Network home health care providers must submit TRICARE claims electronically. The bill type in FL 4 must always be 329 or 339.
- In addition to the blocks noted for the RAP above, each actual service performed with the appropriate revenue code must be listed on the claim form lines. The claim must contain a minimum of five lines to be processed as a final request for anticipated payment. The dates in FL 6 must be a range from the first day of the episode, plus 59 days. Dates on all of the lines must fall between the dates in FL 6.
**Exceptions**

Beneficiaries enrolled in the Custodial Care Transition Program (CCTP) are exempt from the new claim-filing rules and providers treating them may continue fee-for-service billing. For details about beneficiaries grandfathered under the CCTP, refer to the TRICARE Policy Manual, Chapter 8, Section 15.1, at [http://manuals.tricare.osd.mil](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 (AWP). Most durable medical equipment (DME) payments are based on a fee schedule established for each DMEPOS item. The services and/or supplies are coded using CMS Healthcare Common Procedure Coding System (HCPCS) Level II codes that begin with the letters:

- **A** (medical and surgical supplies)
- **B** (enteral and parenteral therapy)
- **E** (DME)
- **K** (temporary codes)
- **L** (orthotics and prosthetic procedures)
- **V** (vision services)

Inclusion or exclusion of a fee schedule amount for an item or service does not imply TRICARE coverage or non-coverage.

In addition to the DMEPOS schedule, parenteral and enteral nutrition items and services and fees are also included. DMEPOS pricing information is available at [http://www.tricare.mil/DMEPOS](http://www.tricare.mil/DMEPOS).

**Home Infusion Drug Pricing**

Home infusion drugs are those drugs (including chemotherapy drugs) that cannot be taken orally and are administered in the home by other means: intramuscularly, subcutaneously, intravenously or infused through a piece of durable medical equipment (DME). DME verification is not required. Home infusion drugs are reimbursed the lesser of the billed amount or 95 percent of the AWP, as retrieved from the National Drug Data File (formerly the National Drug Blue Book). Home infusion drugs must be billed using an appropriate J, Q or S code along with a specific National Drug Code (NDC) for pricing.

Claims for home infusion will be identified by the place of service and the CMS HCPCS National Level II Medicare codes along with the specific NDC number of the administered drug.

**Modifiers**

Industry-standard modifiers are often used with procedure codes to clarify the circumstances under which medical services were performed. Modifiers allow the reporting physician to indicate that a service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers may be used by the 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 with a covered surgical service.
TRICARE covers assistant surgeon services when the services are considered medically necessary and meet the following criteria:

- The complexity of the surgical procedure warrants an assistant surgeon rather than a surgical nurse or other operating room personnel.
- Interns, residents or other hospital staff are unavailable at the time of the surgery.

When billing for assistant surgeon services, please note:

- All assistant surgeon claims are subject to medical review and medical-necessity verification.
- Standby assistant surgeon services are not reimbursed when the assistant surgeon does not actively participate in the surgery.
- The PA or NP must actively assist the operating surgeon as an assistant surgeon and perform services that are authorized as a TRICARE benefit.
- When billing for a procedure or service performed by a PA, the supervising or employing physician must bill the procedure or service as a separately identified line item (e.g., PA office visit) and use the PA’s provider number. The supervising or employing physician of a PA must be a TRICARE-authorized provider.
- Supervising authorized providers that employ NPs may bill as noted for the PA, or the NP may bill on 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 wait for medical review to validate the medical necessity for surgical assistance and possibly have medical records requested. During this review process, the claim also will be reviewed to validate that this facility has (or does not have) residents and interns on staff (e.g., small community hospital).

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**Surgeon’s Services for Multiple Surgeries**

Multiple surgical procedures have specific reimbursement requirements. When multiple surgical procedures are performed, the primary surgical procedure (i.e., the surgical procedure with the highest allowable rate) will be paid at 100 percent of the contracted rate. Any additional covered procedures performed during the same surgical session will be allowed at 50 percent of the contracted rate.

An incidental surgical procedure is one that is performed at the same time as a more complex primary surgical procedure. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure. Therefore, an incidental procedure will not be reimbursed unless it is required for surgical management of multiple traumas or if it involves a major body system different from the primary surgical service.

**Hospice Pricing**

Hospice programs are not eligible for TRICARE reimbursement unless they enter into an agreement with TRICARE. National Medicare hospice rates will be used for reimbursement of each of the following levels of care provided by, or under arrangement with, a Medicare-approved hospice program:

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

The national Medicare payment rates are designed to reimburse the hospice for the costs of all covered services related to treating the beneficiary’s terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice. The only amounts that will be allowed outside of the locally adjusted national payment rates and not considered hospice services will be for direct patient care services rendered by an independent attending physician.
When billing, hospices should keep in mind the following:

- Bill for physician charges/services (physicians under contract with the hospice program) on a UB-04 using revenue code 657 and the appropriate CPT codes.
- Payments for hospice-based physician services will be paid at 100 percent of the TRICARE-allowable charge and will be subject to the hospice cap amount (calculated into the total hospice payments made during the cap period).
- Bill independent attending physician services or patient-care services rendered by a physician not under contract with or employed by the hospice on a CMS-1500 using the appropriate CPT codes. These services will be subject to standard TRICARE reimbursement and cost-sharing/deductible provisions, and will not be included in the cap amount calculations.

The hospice will be reimbursed for the amount applicable to the type and intensity of the services furnished to the beneficiary on a particular day. Each level of care will be paid at the same rate, except for continuous home care, which will be reimbursed based on the number of hours of continuous care furnished to the beneficiary on a given day.

Reimbursement may be extended for routine and continuous hospice care provided to beneficiaries residing in a nursing home facility, that is, physician, nurse, social worker and home health aide visits to patients requiring palliative care for a terminal illness. TRICARE will not pay for the room and board charges of the nursing home.

Note: Continuous home care must be equal to or greater than eight hours per day, midnight to midnight, with at least 50 percent of care provided by licensed practical nursing or registered nursing staff. The rates will be adjusted for regional differences using appropriate Medicare area wage indexes.

**Outpatient Prospective Payment System**

OPPS is the payment methodology used to reimburse for hospital outpatient services.

TRICARE OPPS is mandatory for both network and non-network providers and applies to all hospitals participating in the Medicare program, with some exceptions (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 [SUDRFs])
  - HHAs
  - Hospice programs
  - Other corporate services providers (e.g., freestanding cardiac catheterization and sleep disorder diagnostic centers)
  - SNFs
  - Residential treatment centers

For more information on OPPS implementation, refer to the [TRICARE Reimbursement Manual](http://manuals.tricare.osd.mil), Chapter 13, 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 877-TRICARE (877-874-2273).
As with Medicare, payment will not be made for procedures performed in an outpatient setting which are designated as requiring inpatient care. The list of “Inpatient Only” procedures visit http://www.tricare.mil/inpatientprocedures/.

Temporary Transitional Payment Adjustments

Temporary Transitional Payment Adjustments (TTPAs) are in place for all hospitals, both network and non-network, to buffer the initial decline in payments upon implementation of TRICARE OPPS. For network hospitals, the TTPAs cover a four-year period. The four-year transition sets higher payment percentages for the 10 APC codes for emergency room (ER) and hospital clinic visits (APC codes 604–609 and 613–616), with reductions in each transition year.

For non-network hospitals, the TTPAs cover a three-year period, with reductions in each transition year.

Figure 8.2 shows the TTPA percentages for APC codes 604–609 and 613–616 during the four-year network hospital and three-year non-network hospital transition periods.

<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 Clinic</td>
</tr>
<tr>
<td>Year 1 (5/1/09 – 4/30/10)</td>
<td>200%</td>
<td>175%</td>
</tr>
<tr>
<td>Year 2 (5/1/10 – 4/30/11)</td>
<td>175%</td>
<td>150%</td>
</tr>
<tr>
<td>Year 3 (5/1/11 – 4/30/12)</td>
<td>150%</td>
<td>130%</td>
</tr>
<tr>
<td>Year 4 (5/1/12 – 4/30/13)</td>
<td>130%</td>
<td>115%</td>
</tr>
<tr>
<td>Year 5 (5/1/13 – 4/30/14)</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹ The transition period for network hospitals is four years. In year five, TRICARE’s payment level will be the same as Medicare’s (i.e., 100%).
² The transition period for non-network hospitals is three years. In year four, TRICARE’s payment level will be the same as Medicare’s (i.e., 100%).

Temporary Military Contingency Payment Adjustments

Network hospitals that have received OPPS payments of $1.5 million or more for care provided to ADSMs and ADFMs during an OPPS year (May 1 through April 30) may be given a Temporary Military Contingency Payment Adjustment (TMCPA). Hospitals that qualify for a TMCPA may receive a 15% increase in the total OPPS payments for the second year of OPPS (May 1, 2010 through April 30, 2011). Subsequent adjustments will be reduced by 5 percent each year until the OPPS payment levels are reached in year five (i.e., 10% year three and 5% year four for May 1, 2011 to April 30, 2012).

Filing Claims for PHP Charges

For hospitals NOT subject to OPPS:

Psychological testing conducted while a beneficiary is in an approved PHP will be 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)

For hospitals subject to OPPS:

- The TRICARE OPPS pays claims filed for hospital outpatient services, including hospital-based PHPs (psychiatric and SUDRFs) subject to TRICARE’s prior authorization requirements. The OCE logic will require that hospital-based PHPs provide a minimum of three units of service per day in order to receive PHP payment. Calendar year 2011, payment will be denied for days when fewer than three units of therapeutic services are provided.
TRICARE has adopted Medicare’s PHP reimbursement methodology for hospital-based PHPs. There are two separate APC payment rates under this reimbursement methodology:

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

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

The claim must include a mental health diagnosis and an authorization on file for each day of service. Since there is no HCPCS code that specifies a partial hospitalization related service, partial hospitalizations are identified by means of a particular bill type and condition code.

For more information about how OPPS affects TRICARE PHPs and for a complete listing of applicable revenue and HCPCS codes, refer to the *TRICARE Reimbursement Manual*, Chapter 13, Section 2, at [http://manuals.tricare.osd.mil](http://manuals.tricare.osd.mil).

### 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 8.3.

**Provider Tools**

**Frequently Asked Questions**

**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 predetermined areas, including Base Realignment and Closure Commission sites, and a 40-mile radius around all military treatment facilities.

**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.

**What types of procedures require prior authorization?**

Procedures that require prior authorization vary by beneficiary type. Refer to the Health Care Management and Administration section of this handbook for more information about the rules for prior authorization and how to obtain a list of procedures requiring prior authorization. Access the Prior Authorization, Referral and Benefit Tool at [www.hnfs.com](http://www.hnfs.com) to determine current prior authorization requirements.

**Does TRICARE provide case management?**

Health Net Federal Services, LLC (Health Net), offers case management for beneficiaries with complex medical conditions. See the Health Care Management and Administration section for more information.

**How are maternity patients managed?**

Military medicine focuses on family-centered care before, during and after childbirth. Military treatment facilities in the North Region are committed to being responsive to maternity patients and flexible to their needs. They offer:

- An extended military “family” that is knowledgeable about the separation aspects of military life
- A family-centered-care approach that ensures new military families get the best possible personalized, coordinated maternity care
- Expectant mothers are encouraged to visit [www.tricare.mil/familycare](http://www.tricare.mil/familycare) when deciding where to obtain maternity care. Refer to the Medical Coverage section of this handbook for details on maternity care coverage.

**Does TRICARE Have a Mail Order Pharmacy Program?**

Yes. The TRICARE mail order pharmacy is managed by Express Scripts. Visit [www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE) or call Express Scripts at 877-363-1303 for more information.
Does TRICARE offer any programs for persons with disabilities?

Yes. The TRICARE Extended Care Health Option (ECHO) provides additional benefits to certain beneficiaries. See details about TRICARE ECHO in the TRICARE Program Options section of this handbook.

Does TRICARE have any contracted laboratory services?

Health Net maintains a network of laboratory services in the North Region, which you can view in the provider directory of the Health Net website. Please direct TRICARE beneficiaries to one of the contracted laboratories. When submitting a requisition for a laboratory procedure, please include the appropriate diagnosis code. Make sure the code is specific and consistent with services ordered. Otherwise, the claim will be denied.

How does TRICARE define an emergency?

An emergency is defined as a medical, maternity, or psychiatric condition that would lead a “prudent layperson” (someone with average knowledge of health and medicine) to believe that a serious medical condition exists or that the absence of immediate medical attention would result in a threat to life, limb or sight; or when the person manifests painful symptoms requiring immediate attention to relieve suffering. This includes situations when a beneficiary experiences severe pain.

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

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

How Does TRICARE Define Urgent CARE?

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

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

If you are not available to provide a same-day appointment, you may refer the beneficiary to an urgent care center.

If a TRICARE Prime, TRICARE Prime Remote (TPR), Active Duty Service Members (ADSM) or TRICARE Prime Remote for Active Duty Family Members (TPRADFM) patient 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 877-809-8667. Routine hospital admissions must also be approved by the primary care manager (PCM) or the admission may be covered under the TRICARE Prime point of service option (POS).

Does TRICARE allow a 23-hour outpatient observation status?

Up to 48 hours of outpatient observation services are allowed for physicians to evaluate, stabilize and treat patients for whom a full admission is not clear. If after 48 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 the TRICARE Reimbursement Manual, Chapter 13, at http://manuals.tricare.osd.mil.
Do **TRICARE Prime, TPR and TPRADFM beneficiaries** have coverage outside of this region?

True emergencies are covered for TRICARE Prime, TPR and TPRADFM beneficiaries when traveling away from home, whether they are in or out of their TRICARE region. However, keep in mind:

- Health Net must be notified by the facility within 24 hours, or the next business day, of an emergency inpatient hospital admission.

- Non-emergency care must be approved by the beneficiary’s PCM and authorized by Health Net, when necessary, to ensure maximum TRICARE coverage.

- Routine, out-of-region care for TRICARE Prime, TPR and TPRADFM beneficiaries may be covered under the POS option.

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.

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 website at [www.hnfs.com](http://www.hnfs.com).
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<thead>
<tr>
<th>Acronyms</th>
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<td>ABA</td>
<td>applied behavior analysis</td>
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<tr>
<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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<td>APC</td>
<td>ambulatory patient classification groups</td>
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<td>ASC</td>
<td>ambulatory surgery center</td>
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<tr>
<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>
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<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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<td>CLR</td>
<td>clearly legible report</td>
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<td>CMAC</td>
<td>CHAMPUS maximum allowable charge</td>
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<td>CMN</td>
<td>Certificate of Medical Necessity</td>
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<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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<tr>
<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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<tr>
<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>
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<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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<tr>
<td>EFMP</td>
<td>Exceptional Family Member Program</td>
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<tr>
<td>EFT</td>
<td>electronic funds transfer</td>
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<td>EHHC</td>
<td>ECHO Home Health Care</td>
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<td>EIN</td>
<td>employee identification number</td>
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<tr>
<td>EOB</td>
<td>explanation of benefits</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>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>Abbreviation</td>
<td>Full Form</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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<tr>
<td>NATO</td>
<td>North Atlantic Treaty Organization</td>
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<tr>
<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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<tr>
<td>OHI</td>
<td>other health insurance</td>
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<tr>
<td>OPPS</td>
<td>outpatient prospective payment system</td>
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<tr>
<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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<tr>
<td>PHS</td>
<td>Public Health Service</td>
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<tr>
<td>POS</td>
<td>point of service</td>
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<tr>
<td>PPO</td>
<td>preferred provider organization (TRICARE Extra)</td>
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<tr>
<td>PPS</td>
<td>prospective payment system</td>
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<tr>
<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>
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<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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<tr>
<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 Service Center</td>
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<td>U.S.</td>
<td>United States</td>
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<td>USFHP</td>
<td>US Family Health Plan</td>
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<td>USPHS</td>
<td>United States Public Health Service</td>
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<td>VA</td>
<td>Department of Veterans Affairs</td>
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<td>WPS</td>
<td>Wisconsin Physicians Service</td>
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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 or not a benefit under TRICARE.

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
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 children, adopted children, or stepchildren up to the age of 21 (or 23 if full-time students at approved institutions of higher learning and the sponsors provide at least 50 percent of the financial support). Other beneficiary categories are listed in the TRICARE Eligibility section of this handbook.

Beneficiary Counseling and Assistance Coordinators (BCACs)
Persons at military treatment facilities and TRICARE Regional Offices who are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining medical care through TRICARE. BCACs were previously known as Health Benefits Advisors, or HBAs. To locate a BCAC, visit www.tricare.mil/bcadcdao.

Care Coordination
An approach to care management using proactive methods to optimize health outcomes and reduce risks of future complications over a single, short-term (two to six weeks) episode of care. Prospective and concurrent reviews are used to identify current and future beneficiary needs.

Case Management
A collaborative process normally associated with multiple episodes of health care intervention that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a beneficiary’s
complex health needs. This is accomplished through communication and available resources that promote quality, cost-effective outcomes.

**Catastrophic Cap**

The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given fiscal year (October 1–September 30). Point of service (POS) cost-shares and the POS deductible are not applied to the catastrophic cap.

**Centers for Medicare and Medicaid Services**

The federal agency that oversees all aspects of health care claims filing for Medicare (formerly known as the Health Care Financing Administration).

**Certified Provider**

See the definition for TRICARE-authorized provider.

**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. To be eligible for CHAMPVA, the beneficiary cannot be eligible for TRICARE/CHAMPUS and he or she must be either the spouse or child of a veteran who has been rated permanently and totally disabled for a service-connected disability by a VA regional office; the surviving spouse or child of a veteran who died from a VA-rated service connected disability; the surviving spouse or child of a veteran who was at the time of death rated permanently and totally disabled from a service connected disability or the surviving spouse or child of a military member who died in the line of duty, not due to misconduct (in most of these cases, these family members are eligible for TRICARE, not CHAMPVA). CHAMPVA is administered by the Department of Veterans Affairs and is not associated with the TRICARE program. For questions regarding CHAMPVA, call 800-733-8387 or e-mail hac.inq@va.gov.

**ClaimCheck®**

A customized, automated claims auditing system that verifies coding 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 website at www.hnfs.com for current information regarding the submission of clearly legible reports.

**CMS-1500**

The National Uniform Claim Committee requires the use of the Centers for Medicare and Medicaid Services (CMS) Health Insurance Claim Form (version 08/05) to accommodate the reporting of the National Provider Identifier. The December 1990 version of the CMS-1500 claim form was discontinued and only the revised form is to be used after December 31, 2007. All rebilling of claims must use the revised form from January 1, 2008, forward, even though earlier submissions may have been on the December 1990 version of the CMS-1500 claim form.
**Concurrent Review**

A review performed during the course of a beneficiary’s inpatient admission with the purpose of validating the appropriateness of the admission, level of care, medical necessity, and quality of care, as well as the information provided during earlier reviews. Additional functions performed include screening for case management and identification of discharge planning needs. The review may be conducted by telephone or on site. Concurrent reviews are generally performed when TRICARE is the primary payer. Concurrent reviews are referred for medical director review when they indicate that criteria are not met.

**Copayment**

The fixed amount a TRICARE Prime program option beneficiary will pay for care in the network 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, TRICARE Reserve Select, or TRICARE Retired Reserve. 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).

**Credentialing**

The process that evaluates and subsequently allows providers to participate in the TRICARE network. This includes a review of the provider’s training, educational degrees, licensure, practice history, etc.


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, TRICARE Reserve Select, or TRICARE Retired Reserve 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)**

DEERS is 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. DEERS is the official record system for TRICARE eligibility.

**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 network provider assistance.
**Disease Management**
A prospective, disease-specific approach to improving health care outcomes by providing education to beneficiaries through non-physician practitioners who specialize in targeted diseases.

**Explanation of Benefits**
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 the provider deliberately deceives the regional contractor in order to obtain payment for services not actually delivered or received, or when a beneficiary deliberately deceives the regional contractor to claim program eligibility.

**Grievance**
A grievance is a written complaint or concern from a TRICARE beneficiary or a provider on a non-appealable issue. Grievances address issues of perceived failure by any member of the health care delivery team—including TRICARE military providers, Health Net, or Health Net subcontractor personnel—to provide appropriate and timely health care services, access to care, quality of care, or level of care or service to which the beneficiary or provider feels they are entitled.

**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**
A written decision or explanation of benefits (EOB) denying a TRICARE claim, a request for authorization or a request by a provider for approval as an authorized TRICARE provider, on the basis that the service or provider does not meet TRICARE coverage criteria.
Managed Care
A health care model under which an organization delivers health care to enrolled members and controls costs by closely supervising and reviewing the delivery of health care.

Managed Care Support Contractor (MCSC)
A civilian health care partner of the Military Health System that administers TRICARE in one of the TRICARE regions. An MCSC—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
TRICARE defines an emergency as a medical, maternity, or psychiatric condition that would lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe that a serious medical condition exists; that the absence of immediate medical attention would result in a threat to life, limb, or sight; when a person has severe, painful symptoms requiring immediate attention to relieve suffering; or when a person is at immediate risk to self or others.

Medically Necessary
Appropriate and necessary treatment of the beneficiary’s illness or injury according to accepted standards of medical practice and TRICARE policy. Medical necessity must be documented in clinical notes.

Military Treatment Facility (MTF)
An MTF is a medical facility (hospital, clinic, etc.) owned and operated by the uniformed services and usually located on or near a military base.

National Drug Code (NDC)
The U.S. Food and Drug Administration (FDA) requires companies engaged in the manufacture, preparation, propagation, compounding, or processing of a drug product to register with the FDA and provide a list of all drugs manufactured for commercial distribution. Drug products are identified and reported using a unique three-segment number called the NDC. 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 Health Net or MHN 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 Health Net or MHN, 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,
ementitlement 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 Health Service or
other programs or plans as identified by the TRICARE
Management Activity.

**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.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 rendering services 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 network 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 network 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 network provider.

Supplemental Insurance

Supplemental insurance includes health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance plans, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

Tax Identification Number (TIN)

A TIN is a number assigned by the state in which a business or entity is operated that identifies it for filing and paying taxes related to the business or entity.

Transitional Care

Transitional care is a program that is designed for all beneficiaries to 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

The following forms may be found at www.hnfs.com. If a form is not found on the website, contact a Health Net representative at 877-TRICARE (877-874-2273).

- An Important Message from TRICARE
- 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
- Grievance Form

Health Insurance Claim Form (CMS-1500) Instructions

Claims must be submitted on the CMS-1500 for professional services. The following information is required on every claim:

**BOX 1** Indicate that this is a TRICARE claim by checking the box under “TRICARE CHAMPUS.”

**BOX 1a** Sponsor’s Social Security number. The sponsor is the person that qualifies the patient for TRICARE benefits.

**BOX 2** Patient’s name

**BOX 3** Patient’s date of birth and sex

**BOX 4** Sponsor’s full name. Do not complete if “self” is checked in BOX 6.

**BOX 5** Patient’s address including ZIP code. This must be a physical address. Post office boxes are not acceptable.

**BOX 6** Patient’s relationship to sponsor

**BOX 7** Sponsor’s address including ZIP code

**BOX 8** Marital and employment status of patient

**Note:** Box 11d should be completed prior to determining the need for completing Boxes 9a through 9d. If Box 11d is checked “Yes,” Boxes 9a and 9d must be completed. In addition, if there is another insurance carrier, the mailing address of that insurance carrier must be attached to the claim form.

**BOX 9** Full name of person with 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 23  Prior authorization number
BOX 24A  Date of service
BOX 24B  Place of service
BOX 24C  EMG (emergency) indicator
BOX 24D  CPT/HCPCS procedure code with modifier, if applicable
BOX 24E  Diagnosis code reference number (pointer)
BOX 24F  Charges for listed service
BOX 24G  Days or units for each line item
BOX 24H  Early and Periodic Screening, Diagnosis, and Treatment (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 |
North Region Service Codes

Ambulance Services: F
Anesthesia: 4
Anesthesia Exception: 6
Assistant at Surgery: 0
Behavioral Health: C
Birthing Center: S
Consultation: 9
Darbepoetin: 6
Durable Medical Equipment: G—Purchase; or H—Rental
Epoetin Alpha Injection Codes: 6
Home Infusion Therapy: G
Injections: 6
Maternity: 3
Medical: 6
Mobile Health Providers: 5

Neurology: 6 or P
Orthotic/Prosthetic Procedures: G
Pathology/Laboratory: P or 8
Physical Therapy: D
Radiation Oncology: E
Radiation Therapy: P or E
Radiology: P or 5
Supplies: G
Surgery: 2

Uniform Bill Form (UB-04) Instructions

The following listing of UB-04 form locators is a summary of the Form Locator information.

FL 1 Provider name, physical address and telephone number required
FL 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**

02 Condition is employment related

03 Patient covered by insurance not reflected here

06 ESRD patient in first 30 months of entitlement covered by employer group health insurance

08 Beneficiary would not provide information concerning other insurance coverage

18 Maiden name retained

19 Child retains mother’s name

31 Patient is student (full-time—day)

33 Patient is student (full-time—night)

34 Patient is student (part-time)

36 General Care Patient in a special unit

38 Semi-private room not available

39 Private room medically necessary

40 Same-day transfer

41 Partial hospitalization

46 Nonavailability statement on file

48 Psychiatric residential treatment centers for children and adolescents

55 Skilled Nursing Facility (SNF) bed not available
56  Medical appropriateness
60  Day outlier
61  Cost outlier
67  Beneficiary elects not to use lifetime reserve days
A0  TRICARE External Partnership Program
A2  Physically Handicapped Children’s Program
C1  Approved as billed
C2  Automatic approval as billed based on focused review
C3  Partial approval
C4  Admission/services denied
C5  Post-payment review applicable
C6  Admission pre-authorization
C7  Extended authorization
G0  Distinct medical visit (OPPS)

26  Date Skilled Nursing Facility bed became available
27  Date of hospice certification or re-certification
28  Date comprehensive outpatient rehabilitation plan established or last reviewed
29  Date outpatient physical therapy plan established or last reviewed
30  Date outpatient speech pathology plan established or last reviewed
31  Date beneficiary notified of intent to bill (accommodations)
32  Date beneficiary notified of intent to bill (procedures or treatments)
33  First day of the Medicare Coordination Period for End-Stage Renal Disease (ESRD) beneficiaries covered by Employer Group Health Plan (EGHP)

**Occurrence Span Codes**

01  Auto accident
02  No fault insurance involved—including auto accident/other
03  Accident/tort liability
04  Accident/employment related
05  Accident/No medical or liability coverage
06  Crime victim
21  Date UR notice received
22  Date active care ended
24  Date insurance denied
25  Date benefits terminated by primary payer

**Value Codes and Amounts**

01  Most common semi-private rate
02  Hospital has no semi-private rooms
05  Professional component included in charges and also billed separate to carrier
30  Preadmission testing
31  Patient liability amount
37  Pints of blood furnished
46  Number of grace days
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