August 2023

# TRICARE® Provider NEWS

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## Need Claim Status Details? Use Our Self-Service Options

Health Net Federal Services, LLC (HNFS) makes it easy to find claim details online and through self-service telephone options. Whether you work at a provider's office or a third-party billing agency, please take advantage of these resources.

### Online

Log in at **www.tricare-west.com** to:

- Submit a claim
- Check claim status
- View claims reports
- Request electronic remits
- View and print remits
- Email claims-related questions via the "Ask Us" option
- And more

If you don't currently have a web account with us, click "Register" at the top of most web pages to get started.

### Self-service telephone menu

Follow the prompts when calling 1-844-866-WEST (1-844-866-9378) to listen to claim status details. *Tip:* This is also a convenient way to check patient eligibility! If needed, you may connect with a customer service representative for claim issues or questions that require more detailed or advanced information.

# Care Affiliate™ Upgrade

This summer, Health Net Federal Services (HNFS) is converting to an upgraded version of CareAffiliate, our preferred web tool for submitting pre-authorization and referral requests. While core functions remain the same, with this new version you'll notice:

- Updated color schemes
- New icons and tabs
- Changes to how you navigate to certain features

HNFS will offer updated training materials that walk you through using CareAffiliate at **www.tricare-west.com** > *Provider* > *Education … Quick Reference Guides.*

As a reminder, if you have any issues accessing CareAffiliate or other online tools, contact our web support team at 1-800-440-3114, Monday through Friday, 6:30 a.m.-6 p.m. PT.

# Temporary Adoption of New COVID-19 Treatments Add-On Payment for Diagnosis-Related Groups

For dates of service between Jan. 12, 2023, through May 11, 2023, TRICARE adopted the Centers for Medicare & Medicaid Services' (CMS) New COVID-19 Treatments and Add-On Payment (NCTAP) for diagnosis-related groups (DRGs) under CMS' Inpatient Prospective Payment System. Hospitals can request NCTAPs for eligible inpatient TRICARE beneficiaries who received FDA-approved COVID-19 treatments during this period. To be eligible for an NCTAP, cases must have met all three of the following criteria:

- An FDA-approved drug or biological product authorized by CMS to treat COVID-19 was used
- Dates of service(s) were between Jan. 12, 2023, through May 11, 2023
- Operating costs of the case exceeded the full DRG payment, including the DRG adjustment and any other adjustments under Section 3710 of the CARES Act

For more information on NCTAPs, refer to TRM, Chapter 1, Section 42 or CMS' **NCTAP** page.

# Learn More About Network Provider Credentialing

Health Net Federal Services (HNFS) new credentialing hub at **www.tricare-west.com** > *Provider* > *Take me to… Credentialing* offers tools and information you need to complete credentialing-related tasks. Learn how to:

- Check specific requirements using our new Provider Type Requirements tool. *(Coming soon!)*
- Use our Network TRICARE Provider Roster template.
- Access CAQH ProView or state-specific credentialing application websites.
- Locate credentialing forms.
- Check credentialing status.

We also offer answers to frequently asked questions and other resources.

## *New!* Network TRICARE Provider Roster Tutorial

HNFS' **Network TRICARE Provider Roster** template allows network providers to add and remove providers, and submit demographic updates. Using this template can help expedite claims processing and reimbursement.

Check out our **short video** that walks you through the basics of completing our Network TRICARE Provider Roster template and offers helpful tips on avoiding common mistakes.

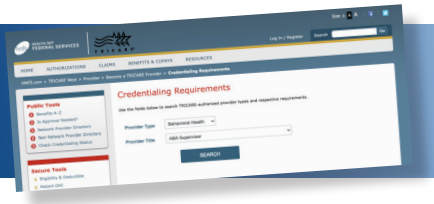

Visit **www.tricare-west.com** > *Provider* > *Take me to… Credentialing* today!

## *Coming Soon!* Provider Type Requirements Tool

Expected later in August, we'll be offering a new tool that will alllow you to quickly learn about TRICARE's credentialing requirements for different provider types in three simple steps.

1. Choose your provider type (behavioral health or physical health)
2. Choose your title from the drop-down list.
3. Click "Search" to return TRICARE requirements.

This tool serves as a checklist for providers new to our network.



# COVID-19 Public Health Emergency Ended

Please review these important TRICARE policy updates resulting from the expiration of the President's and U.S. Department of Health and Human Services (HHS) COVID-19 emergency periods ending.

As of April 11, 2023:

- **Treatment use of investigational drugs:** TRICARE will no longer cover investigational drugs under U.S. Food and Drug Administration (FDA)-approved expanded access programs for the treatment of COVID-19 or associated conditions.
- **Skilled nursing facility (SNF) three-day prior hospital stay requirement:** The requirement for a qualifying hospital stay of three consecutive days or more prior to a SNF admission is no longer waived.
- **Provider licensure flexibilities:** Providers must again be licensed in the state where practicing and where the patient resides.
- **COVID-19 clinical trials:** TRICARE will no longer cover National Institute of Allergy and Infectious Disease (NIAID)-sponsored COVID-19 clinical trials. Eligible beneficiaries who enrolled in a covered trial on or before April 10, 2023, will continue to have their care covered through the end of the trial as long as TRICARE requirements are met.

As of May 12, 2023:

- **COVID-19 testing cost-shares:** TRICARE will no longer waive cost-shares for medically necessary COVID-19 testing. Normal cost-sharing will apply.
- **Coverage of temporary hospitals:** With the expiration of Medicare's Hospitals without Walls initiative, facilities will again have to meet all requirements of Title 32, Code of Federal Regulations, Part 199.6(b).
- **Temporary payment adjustment on inpatient claims for COVID-19 patients:** Reimbursement for inpatient claims for COVID-19/coronavirus patients will no longer reflect the temporary 20% increase to the diagnosis-related group (DRG) weighted rate.
- **Long-term care hospital (LTCH) reimbursement:** Claims for LTCH admissions will be reimbursed at the site-neutral payment rate instead of the LTCH prospective payment system (PPS) standard federal rate.

**Note:** Intensive outpatient programs, medication assistance treatment, and opioid treatment programs may continue to be rendered via telemedicine when medically necessary or appropriate and within the scope of the provider's license. The Drug Enforcement Administration will allow for the prescription of controlled medications via telemedicine through Nov. 11, 2023, or through Nov. 11, 2024, if the practitioner-patient telemedicine relationship was established on or before Nov. 11, 2023.

## Autism Care Demonstration:

Providers helping patients under TRICARE's Autism Care Demonstration (ACD) are in an excellent position to engage parents and caregivers in their children's ABA treatment. To encourage family involvement, TRICARE requires parents or caregivers to participate in a minimum of six training sessions during each six-month authorized treatment period. These sessions are billed as at least one unit of Current Procedural Terminology (CPT®) code 97156 or 97157. Careful and proactive scheduling can help ensure ABA providers and parents/caregivers meet this requirement. If the six-session minimum has not been met for two or more consecutive authorizations, TRICARE policy prohibits regional contractors from reauthorizing subsequent care.

ABA providers must submit reauthorizations 60 to 30 days before an authorized treatment period ends and attach an updated treatment plan that documents parent/caregiver training, including future sessions.

## Meeting Minimum Parent/Caregiver Training Requirements

ABA providers who fail to meet minimum training requirements, include explanations with proposed plans of action, or provide training session details in the treatment plan, will receive a request for consultation from Health Net Federal Services (HNFS). HNFS also will contact ABA providers if training recommendations do not increase or if goals do not become more complex over time.

We offer comprehensive information about parent/caregiver training requirements on our **Initial Assessment** and **Subsequent Authorizations** pages. We also offer printable treatment plan requirements guides on our **Resources** page. ABA providers and parents/caregivers also may contact our dedicated **ACD customer service line** to discuss parent/caregiver training requirements.

# Claims Go to TRICARE or VA (Not Both)

Some TRICARE enrollees are eligible for health care benefits not only through the Department of Defense TRICARE program, but also through the Department of Veterans Affairs (VA) Community Care program. For these dual-eligible beneficiaries, you can file a claim with only one federal agency for payment, either TRICARE or VA, but not to both.

If you file a claim to both TRICARE and VA for the same services, it could lead to double payments. It could appear that you are intentionally seeking double/duplicate payments from the federal government. That could result in recoupment actions, administrative fees, penalties, and fines, as well as the possibility of federal provider exclusion, suspension, or termination.

## Claims for non-emergency care

All non-emergency VA Community Care requires a VA referral for authorization. While dual eligible beneficiaries might be covered by one of several TRICARE health plans, only TRICARE Prime requires referrals for most services. See the decision tree below.

When sending non-emergency claims to TRICARE or VA, remember the following:

- File claims with only one agency, not both. Providers must obtain the appropriate agency referral as required and file claims with the correct agency for payment.
- Dual-eligible beneficiaries using their VA benefit must have a VA referral for provider payment.
- If TRICARE-referred, submit only to TRICARE.
- If VA-referred, submit only to VA.
- If unsure and there is no referral, ask the dual-eligible beneficiary, "Would you like to use your VA or your TRICARE benefit?"

## Claims for emergency care

If you provided emergency care, a referral is not required, but please remember the following:

- Ask the beneficiary to choose VA or TRICARE for claims payment purposes (if they are eligible for both).
- If VA authorizes the care, then properly file the claims with the VA.
- If the beneficiary chooses to use TRICARE, then file the claims with TRICARE.
- If the dual-eligible TRICARE sponsor is not able to respond, you must contact VA within 72 hours using https://EmergencyCareReporting.CommunityCare.va.gov, or by calling 844-72HR-VHA (844-724-7842) to authorize the care provided if VA benefit is expected to be utilized by the beneficiary. This VA hotline is available 24 hours a day.

## Decision tree

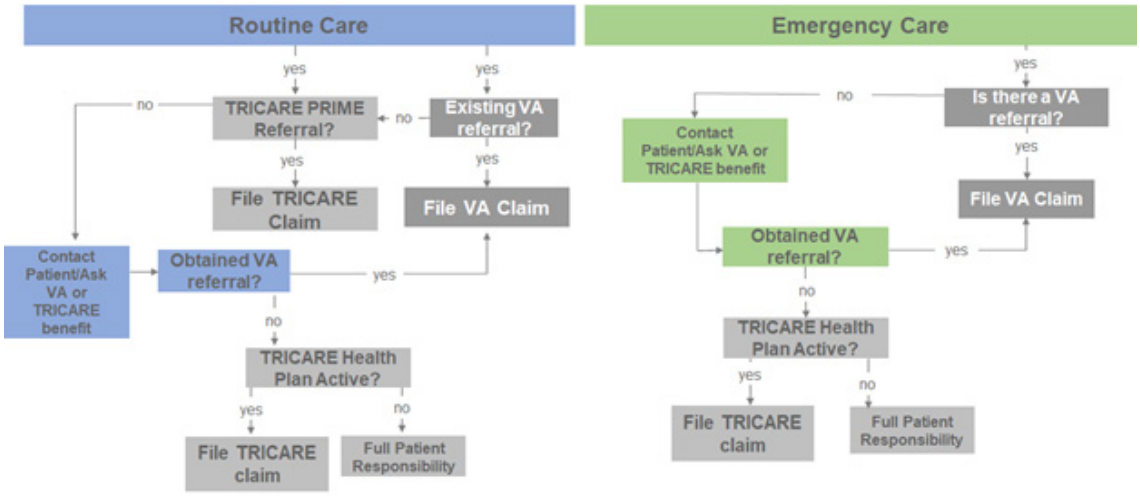



Figure 1. Decision Tree for VA /TRICARE Dual-Eligible Veterans

## TRICARE referral and authorization rules

In general, TRICARE Prime requires referrals for non-emergency care in the private sector. When a dual-eligible TRICARE Prime enrollee is referred to a TRICARE provider for care, Humana Military or Health Net Federal Services is noted as the authorizing agency on the authorization for care. You must file claims for those services in accordance with applicable TRICARE requirements.

TRICARE Select does not require referrals for most care. If a dual-eligible TRICARE Select enrollee does not have an authorization for care from VA, submit your claim to TRICARE. When a dual-eligible beneficiary chooses to use TRICARE benefits or if the VA is unable to authorize care, the provider should follow TRICARE authorization and claims processing instructions.

## Breast Milk Storage Bag Quantity Update

Retroactive to Jan. 25, 2023, TRICARE now covers 100 breast milk bags every 30 days. This change will help with billing by aligning with how breast milk bags are packaged.

As a reminder, breast pumps and supplies are covered beginning week 27 of pregnancy or the birth of a child if prior to 27 weeks, and for mothers who legally adopt who intend to breastfeed. Please visit our **Breast Pumps and Supplies** benefit details page for additional information. We also offer a **Breast Pumps and Supplies Billing Tips** page to assist with claim submissions.

## Dialysis and Freestanding Kidney Dialysis Facility Updates

Implemented July 3, 2023, and retroactive to Jan. 12, 2023, TRICARE has expanded its dialysis coverage to include peritoneal dialysis and treatment for acute kidney injury. Details of TRICARE's dialysis coverage now include inpatient and outpatient dialysis treatments, home dialysis (including training and equipment/ supplies), and other necessary drugs, services, and supplies for dialysis care included in the per-session rate for freestanding kidney dialysis facilities. All services must be medically necessary and appropriate, and the frequency of dialysis services and training must be documented in the patient's medical record. Services provided by dialysis aides, attendants, or assistants are not covered.

Additionally, TRICARE has removed freestanding kidney dialysis facilities (also called freestanding end stage renal disease [ESRD] facilities) from the corporate services provider list and added these facilities to TRICARE's authorized institutional provider list. To be considered a freestanding kidney dialysis facility, facilities must be Medicare certified and meet all Medicare conditions for coverage; be TRICARE participating; and accept payment as full payment as defined per TRICARE Policy Manual (TPM) Chapter 11, Section 2.10.

Freestanding kidney dialysis facilities will be reimbursed a single, flat, per-session fee, which covers facility use, general nursing services, ESRD-related lab services, pharmaceuticals, and supplies.

## Gender-Affirming Surgery Evaluations/ Related Hair Removal Services

Retroactive to March 7, 2023, active duty service members may be eligible for the following under a blanket Supplemental Health Care Program (SHCP) waiver:

- Gender -affirming surgery evaluations
- Medically necessary hair removal by laser or electrolysis related to gender-affirming surgery

Visit our **SHCP web page** to learn more about the waiver process.

# The Importance of Childhood Immunizations

Childhood immunization has consistently proven to be an important part of public health; however, some people are hesitant to get vaccines due to misinformation and concerns about safety. This misinformation and fear have led to decreased immunization rates in some communities. According to the World Health Organization, the number of unvaccinated children doubled from 2 million in 2019 to 4.6 million by 2021 despite efforts to restore routine childhood immunization[1].

The COVID-19 pandemic has had a significant impact on childhood immunization rates. Between inaccurate ideas about vaccine safety and the increasing use of telehealth visits, fewer children are vaccinated each year. In 2020, there was a 10% decline in the number of children who received the recommended vaccines[2].

To help improve childhood immunization rates, you can help advocate for childhood immunizations by actively engaging with parents and communities, promoting evidence-based information, and encouraging in-person newborn care and well-child visits through 24 months of age.

By prioritizing and emphasizing the importance of vaccination, we can safeguard the health and well-being of our young patients and shape a healthier future for generations to come.

[1]World Health Organization. (n.d.). *Focus on unvaccinated children, strengthen routine immunization capacities: Who*. World Health Organization. https://www.who.int/southeastasia/news/detail/12-06-2023-focus-on-unvaccinated-children-strengthen-routine-immunization-capacities-who

[2]Centers for Disease Control and Prevention. (2022, April 1). Childhood immunization schedule. Retrieved from https://www.cdc.gov/vaccines/schedules/index.html

# Improving Human Papillomavirus (HPV) Vaccination Rates

According to the **Centers for Disease Control and Prevention (CDC)**, it is estimated that 36,500 women and men in the U.S. will be diagnosed with a cancer caused by HPV infection each year. Oropharyngeal cancer is the most common cancer, with **14,000 cases each year,** making it higher than cervical cancer, with 11,000 new cases yearly. HPV vaccination could **prevent more than 90% of cancers caused by HPV** from ever developing, which is an estimated 33,700 cases in the U.S. every year.

The CDC offers these five strategies to **boost vaccination rates**:

- Bundle your recommendation for all adolescent vaccines on the same day.
- Ensure a consistent message for your patients by training your office staff on recommendations, vaccination practices and answering questions.
- Use every opportunity to vaccinate by establishing an office policy to check immunization status at every visit.
- Provide personal examples of how you support vaccinations for your family members.
- Effectively **answer some of the most commonly asked questions** from parents about HPV.

You can also visit the CDC website to review their **Top 10 Tips for HPV Vaccination Success**.

Check out our **Provider Toolkit** for resources on sexual health and cancer prevention. The CDC has **educational materials** you can print and display in your office or give to patients. They also have a **vaccination schedule** available for you to use as a resource.

# How to Know if the Drug You're Prescribing Is Covered by TRICARE

Before you send your patient's prescription to a pharmacy, it is important to confirm the coverage rules that apply. The **Formulary Search Tool (FST)** is a digital tool that provides pharmacy product coverage details for the TRICARE pharmacy benefit, managed by Express Scripts.

When you search for a medication using the FST you will find:

- Advanced medication search options by strength, route, form, or type
- Prior authorization and medical necessity forms
- TRICARE formulary information on products including alternate names, drug options, FAQs.

You can also review requirements for military and retail pharmacies and home delivery:

- Check dispensing/fill location options for each product/ medication
- Find medication copayments based on the dispensing/fill location
- Locate quantity limitations, day supply, step therapy, or prior authorization/medical necessity clinical requirements

If your patient needs a medication that requires prior authorization, such as a non-formulary drug, before sending them to the pharmacy, make sure to submit a request to Express Scripts for review. You can do this electronically, by fax, or over the phone:

- Electronically submit through your desired ePA portal and select TRICARE as the benefit plan
- Download or print a form at **www.esrx.com/tform** and fax the completed form to1-866-684-4477
- Call Express Scripts' Coverage Review Department at 1-866-684-4488

Scan the QR code to learn more about how Express Scripts can support you and your patients or visit **https://militaryrx.express-scripts.com/healthcare-providers**.

# TRICARE's Right of First Refusal

When a TRICARE Prime beneficiary is referred for specialty care, TRICARE requires Health Net Federal Services (HNFS) to first attempt to coordinate care at a military hospital or clinic, even if the beneficiary is enrolled to a civilian primary care manager. This process is known as TRICARE's right of first refusal. Providers should include as much clinical documentation or as many details as possible when submitting referrals to HNFS, as this will help military hospitals and clinics to reasonably determine if they can effectively treat the beneficiary.

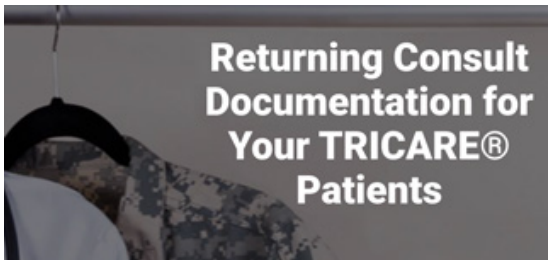
Be sure to review the details of approval letters issued by HNFS with your TRICARE patients. Each letter will specify the approved specialty provider. If a beneficiary sees a provider other than who was approved, point-of-service charges may apply. Beneficiaries and providers can access copies of approval letters through our secure **Authorization Status** tool (log in required).

# Learn the Basics About Submitting Consult Reports to Referring Military Providers

If you are treating a TRICARE patient who was referred by a military hospital or clinic, you will need to submit consult documentation – also known as patient encounter reports or clear and legible reports (CLRs) – to the referring provider within required time frames. Consult documentation includes consultation reports, care notes, operative reports, and discharge summaries.

We encourage you and your staff to check out our online module, "**Returning Consult Documentation for Your TRICARE Patients**." The module, which takes less than 10 minutes to complete, covers:

- Why consult reports are important
- The patient continuum of care
- Timeliness standards for returning consult documentation
- Where and how to submit consult documentation to military hospitals and clinics.




As a reminder, once you have rendered care, the "clock" for returning consultation or initial assessment documentation begins.

| Consultation Type | Consultation Standard |
|---|---|
| **Emergent care** | Send within **24 hours** |
| **Urgent care** | Send within **48 hours** |
| **All others (*except mental health)** | Send within **seven business days** |
| **Mental health assessment** | Mental health care providers: Submit brief initial assessments within **seven business days**. |

Visit our **Consultation Reports** page to learn more.

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CONTACTS

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Pharmacy inquiries
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www.militaryrx.express-scripts.com

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