TRICARE provider handbook

South Region 2017

Humana Military

TRICARE®

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TRICARE provider handbook: South Region 2017

Your guide to TRICARE programs, policies and procedures

An important note about TRICARE program information

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

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

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Welcome to TRICARE and the South Region

What is TRICARE?

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

TRICARE-eligible beneficiaries may include Active Duty Service Members (ADSMs) and their families, retired service members and their families, National Guard and Reserve members and their families, survivors, certain former spouses and others.

TRICARE brings together military and civilian health care professionals and resources to provide high-quality health care services. TRICARE is managed in three stateside regions — TRICARE North, TRICARE South and TRICARE West.

In these U.S. regions, TRICARE is managed by the Defense Health Agency (DHA) and has contracted with civilian regional contractors in the North, South and West regions to assist TRICARE regional directors and military hospital commanders in operating an integrated health care delivery system.

TRICARE offers comprehensive medical benefits to all TRICARE beneficiaries, as well as pharmacy and dental benefits. Depending on a beneficiary's status and location, he or she may be eligible for different program options. TRICARE Prime is a managed care option offering the most affordable and comprehensive coverage. TRICARE Standard/TRICARE Extra involves cost-shares and deductibles. Active Duty Service Members fall under SHCP, otherwise they are automatically enrolled in the PRIME option. Active Duty Family Members (ADFMs), retirees and their families, and others may choose to enroll in TRICARE Prime or use TRICARE Standard/TRICARE Extra.

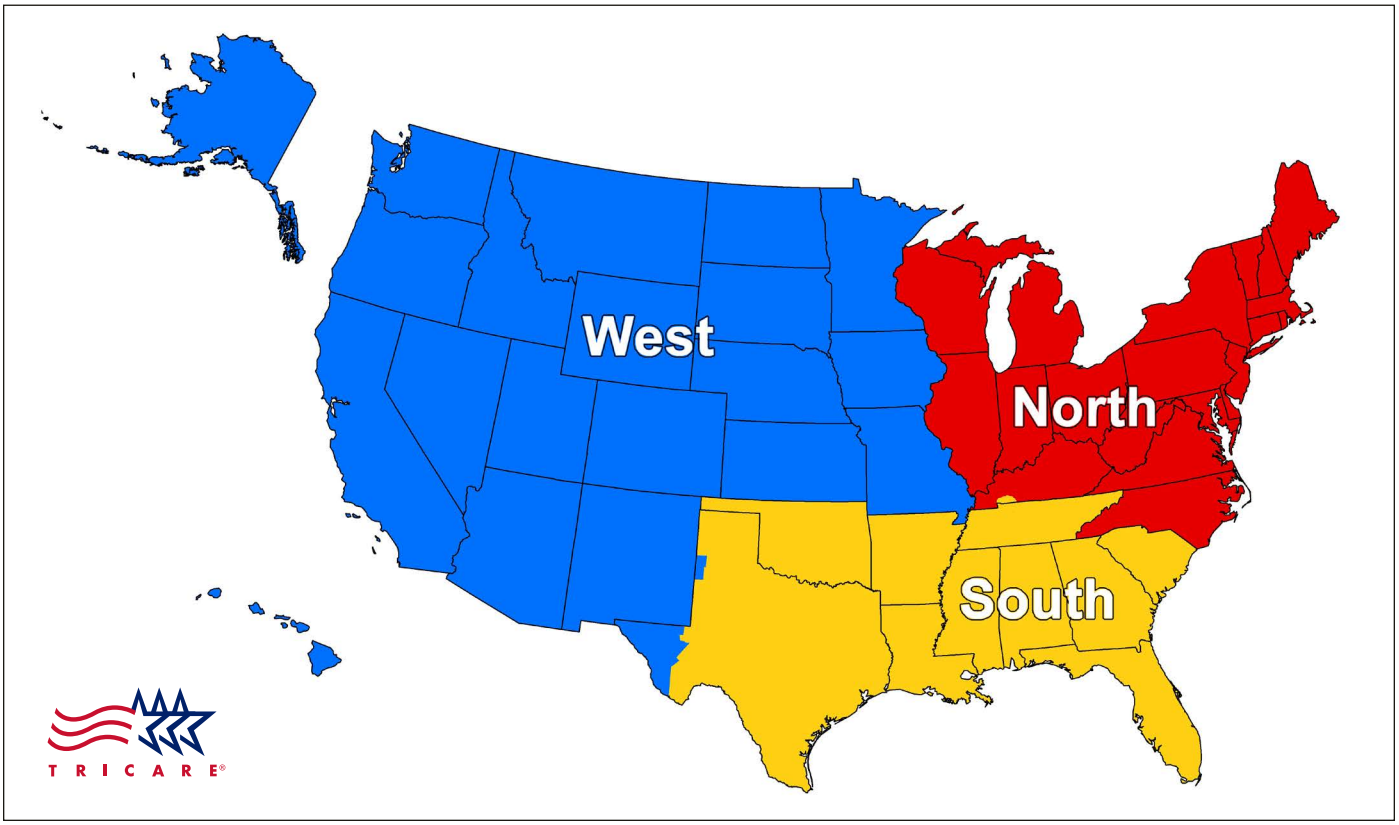
Visit ***TRICARE.mil*** for detailed information about all of TRICARE's plans and programs.

TRICARE Regions:

North Region
Health Net Federal Services, LLC
HNFS.net
Customer service line:
1-877-TRICARE (1-877-874-2273)

South Region
Humana Military
HumanaMilitary.com
Customer service line:
1-800-444-5445

West Region
UnitedHealth Military & Veterans Services
UHCMilitaryWest.com
Customer service line:
1-877-988-WEST (1-877-988-9378)



Your regional contractor

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

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

The figure on page six displays a map of the three TRICARE regions in the United States. **The figure below** shows the TRICARE South Region.

Humana Military network subcontractors and vendors

Humana Military administers the South Region TRICARE contract and utilizes partnerships for certain services:

- ValueOptions Federal Services Inc. (VOFS), a Beacon Health Options company, is Humana Military's mental health care subcontractor in the TRICARE South Region. ValueOptions Federal Services, is a wholly-owned subsidiary of Beacon Health Options, Inc. (f/k/a ValueOptions, Inc.), which is a wholly-owned subsidiary of FHC Health Systems, Inc., the largest privately held mental health managed care company in the nation.
- PGBA, LLC (PGBA) is Humana Military's claims processing contractor in the TRICARE South Region. PGBA is a wholly-owned subsidiary of BlueCross BlueShield of South Carolina and a member of the Celerian Group.

HumanaMilitary.com

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

Visit **HumanaMilitary.com** to:

- Learn about TRICARE programs and coverage.
- Access forms and tutorials.
- Learn about provider education opportunities.
- Get billing guidelines.
- Locate TRICARE providers using the "**provider locator**" tool.
- Access **self-service for providers portal**, Humana Military's secure self-service portal.

TRICARE policy resources and manuals

manuals.tricare.osd.mil

The DHA provides Humana Military with guidance — as issued by the DoD — for administering TRICARE-related laws. The DoD issues this direction through modifications to the Code of Federal Regulations (CFR). As well as implementing improvements according to the National Defense Authorization Act (NDAA) with congressional approval.

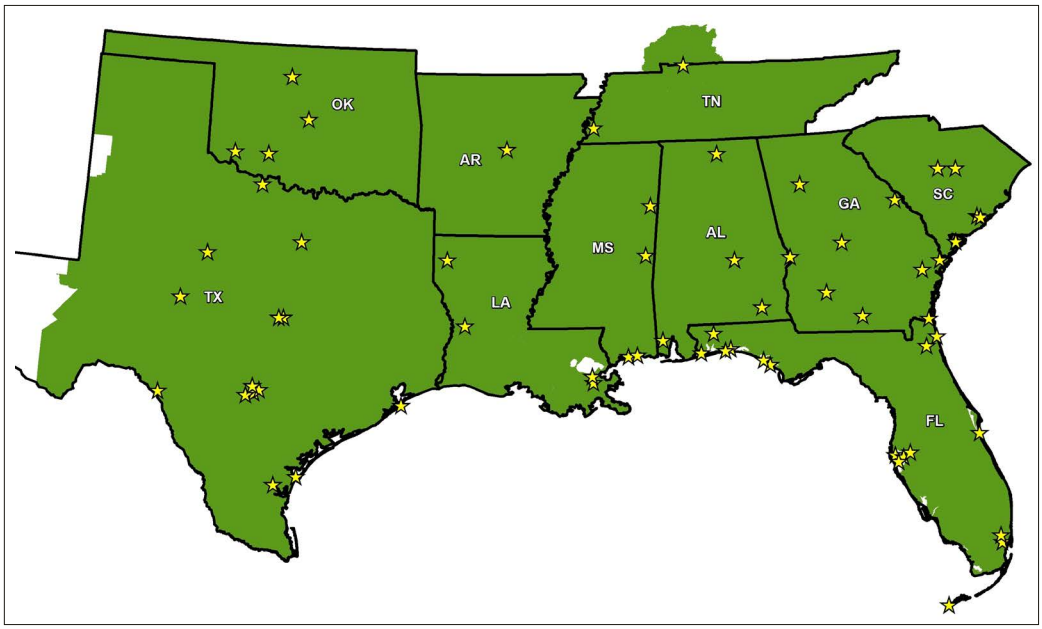
The *TRICARE Operations Manual*, *TRICARE Reimbursement Manual* and *TRICARE Policy Manual* are continually updated to reflect changes in the CFR. Depending on the complexity of the law and federal funding, it can take a year or longer before the DoD provides direction for administering new policy.

Note: TRICARE-related statutes can be found in chapter 55 of title 10 of the United States Code, which contains all the statutes regarding the armed forces. Unless specified otherwise, federal laws supersede state laws.

This *TRICARE provider handbook* provides an overview of the TRICARE program regulations and requirements contained in the *TRICARE Policy Manual*, *TRICARE Operations Manual* and *TRICARE Reimbursement Manual*. To view the complete manuals and other TRICARE policies, visit ***manuals.TRICARE.osd.mil***

Refer to these TRICARE manuals and **HumanaMilitary.com** for current information about policy changes, time lines and implementation guidance.

TRICARE South Region:



Provider resources

Humana Military resources

Resource/contact information	Services provided	
	Secure services	Non-secure services
HumanaMilitary.com (Access secure features via the **self-service for providers portal**)	• Verify patient eligibility • Create referrals and authorizations • Review referrals and authorizations • Check claim status • Manage your profile • Access pharmacy data by patient • Look up codes	• Learn about TRICARE programs and coverage • Access forms and tutorials • Learn about provider education opportunities • Get billing guidelines • Locate TRICARE providers using the "**provider locator**" • Access the *TRICARE provider handbook* and editions of the *South Region provider news*
Humana Military Interactive Voice Response (IVR) line **1-800-444-5445**	• Look up procedure codes • Check the status of claims • Determine eligibility and covered benefits • Check the status of referrals, authorizations and mental health referrals	

South Region claims resources

Resource	Contact information	Continued Health Care Benefit Program	
Claims: PGBA	PGBA South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 **1-800-403-3950**	For questions and assistance regarding Continued Health Care Benefit Program (CHCBP) claims, call PGBA at **1-800-403-3950**. • File CHCBP claims electronically at *myTRICARE.com* • File all corresponding paper claims at one of the following:	
		CHCBP Behavioral Health Claims P.O. Box 7034 Camden, SC 29021-7034	**All Other CHCBP Claims** P.O. Box 7031 Camden, SC 29020-7031
TRICARE For Life claims information	WPS/TDEFIC P.O. Box 7889 Madison, WI 53707-7889 **1-866-773-0404** **1-866-773-0405 (TDD)**		
PGBA Electronic Data Interchange (EDI) Help Desk **1-800-325-5920**		• Get assistance with isues related to TRICARE Electronic Media Claims (EMC) submissions • Identify yourself as a TRICARE provider	

Out-of-region claims

North Region	Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740 **1-877-TRICARE** *hnfs.net*	**West Region**	PGBA, LLC TRICARE WEST REGION P.O. Box 7064 Camden, SC 29020-7064 **1-877-988-WEST**	**Overseas Region**	See section 5 of the *TRICARE provider handbook* for details on filing claims for overseas beneficiaries.

*The information contained in these charts is **not** all-inclusive.*

Medicare and TRICARE claims

Wisconsin Physicians Service/TRICARE Dual Eligible Fiscal Intermediary Contract (WPS/TDEFIC) is the claims processor for all TFL claims. Providers who currently submit claims to Medicare on a patient's behalf do not need to submit a separate claim to WPS/TDEFIC.

Appeals	WPS/TRICARE For Life Attn: Appeals P.O. Box 7490 Madison, WI 53707-7490	**Refunds**	WPS/TRICARE For Life Attn: Refunds P.O. Box 7928 Madison, WI 53707-7928
Claims submission (**Note:** Submit claims to medicare first.)	WPS/TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890	**Third-Party Liability**	WPS/TRICARE For Life Attn: TPL P.O. Box 7897 Madison, WI 53707-7897
Customer service	WPS/TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889	**Toll-free telephone**	**1-866-773-0404**
Online	*TRICARE4u.com*	**Toll-free TDD**	**1-866-773-0405**
Program Integrity	WPS/TRICARE For Life Attn: Program Integrity P.O. Box 7516 Madison, WI 53707-7516		

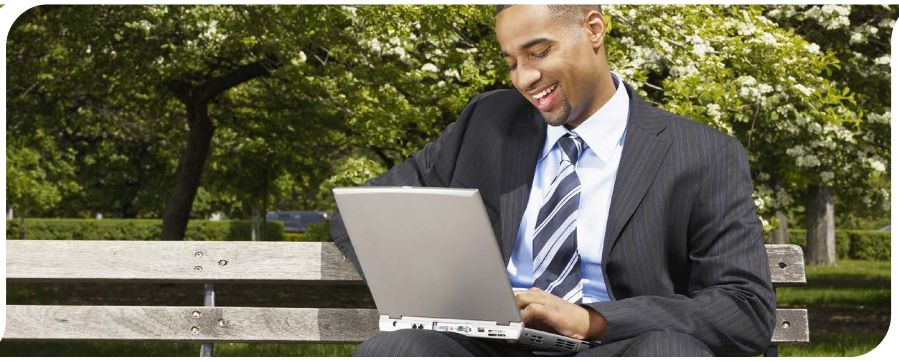
Additional South Region resources

Resource	Contact information
Mental health care partner: ValueOptions Federal Services, Inc.	ValueOptions Federal Services P.O. Box 551188 Jacksonville, FL 32255-1188 **1-800-700-8646** **HumanaMilitary.com**
PGBA provider data management updates	TRICARE South Region Data Management Dept. P.O. Box 7031 Camden, SC 9021-7031 Fax: **1-803-462-3993**
Fraud and abuse hotline	**1-800-333-1620** **HumanaMilitary.com**

National resources

Resource	Contact information
TRICARE website	*TRICARE.mil*
TRICARE manuals online	*manuals.tricare.osd.mil*
Defense Health Agency Great Lakes	Defense Health Agency - Great Lakes 2834 Green Bay Road, Suite 304 North Chicago, IL 60064-3091 **1-888-MHS-MMSO (1-888-647-6676)**

*The information contained in these charts is **not** all-inclusive.*



TRICARE pharmacy resources	
Resource	Contact information
TRICARE Pharmacy Program: Express Scripts, Inc.	**Express Scripts, Inc.** **P.O. Box 52150** **Phoenix, AZ 85072** **Phone: 1-877-363-1303 Fax: 1-877-895-1900** *express-scripts.com/TRICARE*
TRICARE Formulary Search Tool	*express-scripts.com/static/formularySearch/2.1/#/formularySearch/drugSearch*
Pharmacy prior authorization information and forms (Includes requests for medical necessity & criteria for non-formulary medications)	**Located on formulary search tool under specific drug.** File electronically using **CoverMyMeds**: *covermymeds.com/epa/express-scripts*
Provider Customer Service Line	**1-877-363-1303, Option 6**
Other program resources	
Resource	Contact information
Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)	*va.gov/purchasedcare/programs/dependents/champva* **VA Health Administration Center CHAMPVA** **P.O. Box 469063** **Denver, CO 80246-9063** **1-800-733-8387**
TRICARE For Life (TFL) **Wisconsin Physicians Service/TRICARE Dual Eligible Fiscal Intermediary Contract (WPS/TDEFIC)**	*TRICARE4U.com* **WPS/TDEFIC** **P.O. Box 7889** **Madison, WI 53707-7889 (general correspondence only, no claims)** **1-866-773-0404** **1-866-773-0405 (TDD)**
US Public Health Service (USPHS)	**1-800-279-1605**
Warrior Navigation and Assistance Program (WNAP)	**HumanaMilitary.com/beneficiary/plans-and-programs/wnap** **1-888-4GO-WNAP (1-888-446-9627**

Important provider information

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

Healthy People 2020

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

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

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

The Healthcare Effectiveness Data and Information Set (HEDIS) performance measures

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

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

The DHA has challenged Humana Military to collaborate with its network providers to improve the HEDIS scores of TRICARE beneficiaries.

Improving HEDIS scores is another element of Humana Military's ongoing efforts to help TRICARE beneficiaries improve their health and better manage chronic health conditions. This goal also supports the population health segment of the DHA's Quadruple Aim.

This segment seeks to reduce generators of ill health by encouraging healthy behaviors and decreasing likelihood of illness through focused prevention and increased resilience.

Search for more information on **HEDIS** at **HumanaMilitary.com**

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

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

In the Military Health System (MHS), one of the most important exceptions to the authorization requirement is the military command exception. This permits limited disclosures of PHI about Active Duty Service Members (ADSMs) to their military commanders to determine fitness for duty or certain other purposes. Similarly, PHI of service members separating from the armed forces may be disclosed to the U.S. Department of Veterans Affairs (VA). For more detailed guidance and information on the HIPAA Privacy Rule, search for **privacy** at **HumanaMilitary.com**

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

Military Health System Notice of Privacy Practices and other information sources

The *Military Health System Notice of Privacy Practices* form informs beneficiaries about their rights regarding PHI and explains how PHI may be used or disclosed, who can access PHI and how PHI is protected. The notice is published in 11 languages. Braille and audio versions are also available.

Visit ***TRICARE.mil/TMA/privacy/HIPAA-NOPP.aspx*** to download copies of the *Military Health System Notice of Privacy Practices*. They serve as beneficiary advocates for privacy issues and respond to beneficiary inquiries about PHI and privacy rights.

For more information about privacy practices and other HIPAA requirements, visit ***TRICARE.mil/HIPAA***. Beneficiaries and providers may also e-mail inquiries to ***privacymail@dha.osd.mil***

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

Patient Bill of Rights

MHS patients have explicit rights about information disclosure; choice of providers; health plans; access to emergency services; participation in treatment decisions; respect and nondiscrimination; privacy and security of personally identifiable information, complaints, and appeals; as well as specific responsibilities to participate in their own health decisions.

Through these rights, patients are able to participate in their own care, be assured that they are receiving the best care possible, and can trust that their personal information will remain secure throughout the treatment process.

For details about the Patient Bill of Rights, view page 35 of the *TRICARE Standard Handbook*: ***TRICARE.mil/~/media/Files/TRICARE/Publications/Handbooks/TSE_HBK.pdf***

What is a TRICARE provider?

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

TRICARE-certified providers vs. TRICARE network providers

TRICARE-authorized providers

- TRICARE-authorized providers meet state licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (nurse practitioners, physician assistants and physical therapists), laboratory and radiology providers, and pharmacies. Beneficiaries are responsible for the full cost of care if they see providers who are not TRICARE-authorized.
- TRICARE covers services delivered by qualified TRICARE-authorized mental health care providers and ABA practicing within the scope of their licenses to diagnose and/or treat covered mental health components of an otherwise diagnosed medical or psychological condition.
- There are two types of TRICARE-authorized providers: **Network** and **non-network**.

Network providers[1]

Regional contractors have established networks, within a forty mile radius of the military hospitals or clinics.

TRICARE network providers:

- Have agreements with Humana Military to provide care. For mental health services, agreements are with ValueOptions Federal Services.
- Agree to file claims and handle other paperwork for TRICARE beneficiaries.

Non-network providers[2]

Non-network providers do not have agreements with Humana Military or ValueOptions Federal Services and are therefore considered non-network.

There are two types of non-network providers: **Participating** and **nonparticipating**.

Participating providers

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

Nonparticipating providers

- 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 percent above the TRICARE allowable charge for services

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

TRICARE network providers

File claims with PGBA on behalf of all TRICARE eligible beneficiaries. Whenever a Standard beneficiary utilizes a network provider, they are exercising their "Extra" option for lower out of pocket-cost share. Network providers are expected to accept assignment on all covered TRICARE services and submit claims electronically.

Non-network TRICARE-authorized providers

Non-network providers who are authorized to see TRICARE eligible beneficiaries are TRICARE certified and accept assignment on a claim by claim basis. Participation with TRICARE (e.g., accepting assignment, filing claims and accepting the TRICARE allowable charge as payment in full) is encouraged. Non-network providers should submit their TRICARE claims electronically.

If a non-network provider does not accept assignment and participate on a particular claim, beneficiaries must file their own claims with TRICARE and then pay the non-network provider.

Note: By federal law, if a non-network provider does not participate on a particular claim, the provider may not charge beneficiaries more than 15 percent above the TRICARE allowable charge.

Military hospitals or clinics (MTF)

A military hospital or clinic is a healthcare facility usually located on a military base. "**Right of First Refusal**" is an attempt to bring beneficiary care back into the military hospitals or clinics where capabilities exist. The civilian TRICARE provider network supplements military hospital or clinic resources and may work closely with the military hospitals or clinics commander to ensure patients get the care they need. To locate a military hospital or clinic, visit ***TRICARE.mil/MTF***

Primary Care Managers (PCMs)

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

When required, PCMs work with Humana Military to obtain referrals and prior authorizations. See the **health care management and administration** section for more information about referral and authorization requirements.

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

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

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

Corporate Services Provider (CSP) class

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

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

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

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

Provider certification and credentialing TRICARE certification

TRICARE only reimburses appropriate covered services for eligible beneficiaries provided by TRICARE-authorized providers. TRICARE-authorized providers must meet TRICARE licensing and certification standards and must comply with regulations specific to their health care areas.

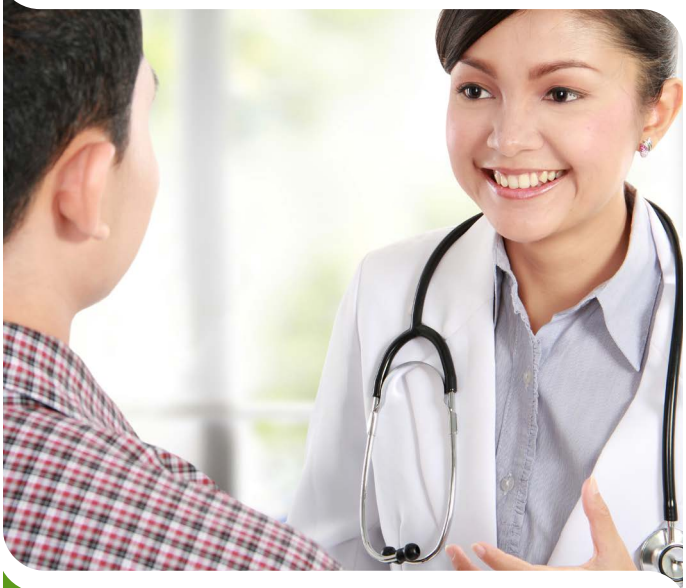
Certified providers are considered non-network TRICARE-authorized providers. Non-network providers may also choose to "**accept assignment**" (i.e., participate) on a case-by-case basis.

All providers must submit certification forms to PGBA to become a TRICARE-certified provider. To download the forms, visit *myTRICARE.com* and search for "**provider forms South**."

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

Once KePRO certifies the facility, the provider must complete the ValueOptions Federal Services contracting process. Contact ValueOptions Federal Services by e-mail at ***provhelptricare@jax.valueoptions.com*** or by phone at **1-800-700-8646** for more information.

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



Credentialing

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

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

- Have graduated from a school appropriate to their profession and completed postgraduate training appropriate to their practicing specialty
- Have a current, valid, unrestricted and un-probated professional state license* in the state(s) they practice within
- Have a current, valid, unrestricted and un-probated Drug Enforcement Agency (DEA) registration, if applicable to their practicing specialty
- Have a current, valid, unrestricted and un-probated State Controlled Dangerous Substance registration, if applicable to their practicing specialty and the state they practice within
- Have current professional liability insurance or meet the state/local guidelines
- Be able to participate in federal health care programs.
- Not have been convicted of a felony related to controlled substances, health care fraud or a child or patient abuse
- Not have any physical or mental health condition that cannot be accommodated without undue hardship or without reasonable accommodation
- Not have untreated chemical/substance dependency
- Not have any unexplained gaps of six months or more in their work history during the past five years

*See the *TRICARE Policy Manual* 6010.54-M, August 1, 2008, chapter 11, section 3.2, State Licensure and Certification Policy.

Providers requiring credentialing include:

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

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

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

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

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

Right to appeal

Humana Military has established minimum credentialing/eligibility criteria for inclusion in the provider network. Failure to meet the minimum credentialing/eligibility criteria established by the Credentialing Committee is not reportable to any external agency (i.e. the NPDB).

To appeal a decision, Humana Military must receive notification of the appeal within 14 calendar days of the provider's notification that minimum credentialing/eligibility was not met. All documentation must be included to support the appeal. The appeal and documentation will be reviewed by the First Level Review Panel. Notification of outcome will be in writing. Failure to comply with the time frame constitutes a waiver of the right to appeal.

Note: The *TRICARE Policy Manual* 6010.57-M, February 1, 2008, chapter 11, section 3.2, State Licensure and Certification Policy states, "A. State Licensure/Certification. Otherwise covered serves shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the state where service is rendered. Licensure/certification in a profession other than that for which the provider is seeking authorization is not acceptable. The licensure/certification must be at the full clinical level of practice. Full clinical practice level is defined as an unrestricted license that is not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction. Individual placed on probation or whose license has otherwise been restricted are not considered to be practicing at the full clinical practice level.

Mental health care providers — including freestanding PHPs, RTCs and SUDRFs — must be credentialed by ValueOptions Federal Services. For credentialing criteria and to download a writable PDF application for behavioral health providers, see the **mental health care services** section of this handbook, or search "**Join the network**" at **HumanaMilitary.com**

Provider responsibilities

Network providers have contracts with Humana Military and must comply with all TRICARE program rules and regulations and Humana Military policies.

This handbook is not all-inclusive and is intended to provide an overview of TRICARE program rules and regulations and Humana Military policies and procedures. Visit **HumanaMilitary.com** for more information about provider responsibilities.

Verifying eligibility

TRICARE beneficiaries are required by law to present identification confirming their eligibility for TRICARE coverage, even if they have Other Healthcare Insurance. A military ID card is the most common form of identification; however, an ID card alone may not be proof of eligibility or current coverage. Humana Military encourages providers to use the **self-service for providers portal** to verify eligibility, confirm status for copay/costshare patient responsibility, and catcap. Providers can request to copy the military ID for the patient medical record….especially if they are travelling and are **out of region**. For **in region** eligibility checks on the secured provider portal, the provider office can print the screen which is date stamped and includes all the coverage information needed for the patient record. Providers have the right to collect out of pocket copay or costshare at the completion of the appointment where applicable.

Missed appointments

TRICARE regulations do not prohibit providers from charging missed appointment fees. TRICARE providers are within their rights to enforce practice standards, as stipulated in clinic policies and procedures that require beneficiaries to sign agreements to accept financial responsibility for missed appointments. TRICARE does not reimburse beneficiaries for missed appointment fees.

Nondiscrimination policy

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

Office and appointment access standards

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

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

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

Primary Care Manager's (PCM's) role

PCMs are network providers who have agreed to "**accept patients**" for primary care services at the time of the eligible beneficiary's enrollment in TRICARE. The PCM is an individual provider within a military or civilian setting.

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

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

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

  - Routine care: The PCM or on-call provider instructs the TRICARE Prime beneficiary to contact the PCM's office on the next business day for an appointment
  - Urgent care: The PCM or on-call provider coordinates timely care for the TRICARE Prime beneficiary
  - The on-call physician should contact the PCM within 24 hours of an inpatient admission to ensure continuity of care

- PCMs referring patients for specialty care may need to coordinate the referral with Humana Military
- ADSMs **must** have referrals for all care outside of military hospitals and clinics (except for emergencies or as provided in TRICARE Prime Remote [TPR] regulations, if applicable), including all mental health care services. If the ADSM has an assigned civilian PCM under TRICARE Prime or TPR, all specialty referral and authorization guidelines must be followed

Specialty care responsibilities

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

TRICARE Prime beneficiaries who live within a 60-minute drive time of a military hospital or clinic may be required to first seek specialty care, ancillary services and physical therapy at the military facility based on it's Right Of First Refusal (ROFR).

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

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

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

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

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

Providers should request referrals and prior authorizations via the secure **self-service for providers portal** at **HumanaMilitary.com**. Humana Military/ValueOptions Federal Services accepts requests via fax if the provider is not able to submit electronically.

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

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

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

Moonlighting providers

Medical Personnel who are part of the Uniformed Services-Active Duty, Reserve/Guard on Active Duty, Civil Service and government contracted employees cannot receive dual compensation for services provided to TRICARE beneficiaries. If the medical personnel are actively being compensated through normal pay by the government, it is a conflict of interest for the medical personnel to "treat" TRICARE beneficiaries in a civilian setting and receive payment for those services. The Department of Defense and other government departments are responsible to ensure appropriate dispersion of funds in the payment of TRICARE benefits.

Federal law prohibits moonlighting ADSM and civilian government employed health care providers from billing TRICARE for any professional fees incurred in treating TRICARE-eligible beneficiaries. Civilian medical facilities who employ military or government civilian moonlighting health care providers are also prohibited from billing TRICARE for any professional fees incurred by the above providers.

Per U.S. Title 32, Code of Federal Regulations (CFR) and TRICARE policy, ADSM and government employed civilian providers who moonlight are prohibited from serving as authorized TRICARE providers. As a result, these providers may not bill TRICARE for professional services furnished to eligible beneficiaries, regardless of location served.

Electronic and paper CMS-1500 and UB-04 claim forms distinctly cite, "For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military." Billing TRICARE for services or supplies as described above will result in denied claims, recoupment and/or possible fraud investigation.

Department of Veterans Affairs (VA) health care facilities

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

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

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

Department of Veterans Affairs (DVA) and Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)

A facility understands that, through this network agreement, it agrees to being reported to the Department of Veterans Affairs (DVA) and to Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) as a TRICARE network provider. This agreement will give the DVA the right to directly contact the facility and request care on a case by case basis for VA patients or CHAMPVA beneficiaries if the facility availability allows. The facility understands that it is not required to meet access standards for CHAMPVA beneficiaries, but is encouraged to do so. The facility understands that CHAMPVA beneficiaries are not to receive preferential appointment scheduling over a TRICARE beneficiary.

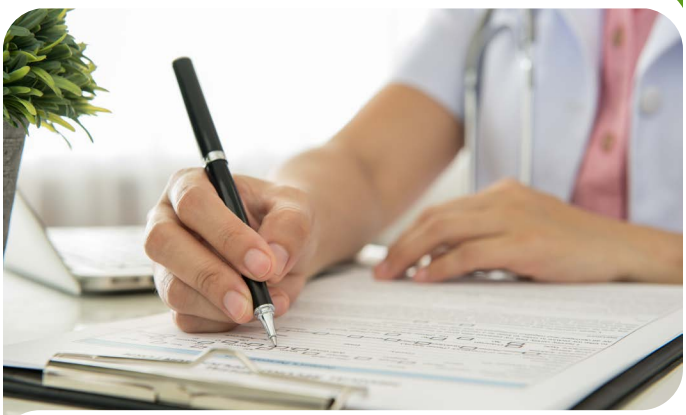
Emergency care responsibilities

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

Humana Military reviews admission information and authorizes continued care, if necessary. If TRICARE Prime enrollees seek non-emergency care without required referrals and/or authorizations, they are responsible for paying POS fees.

Urgent care

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



Balance billing

A TRICARE network provider agrees to accept the rates and terms of payment specified in its agreement with Humana Military as payment for a covered service. Participating non-network provider agrees to accept the TRICARE allowable charge as payment in full for a covered service. These providers may not bill TRICARE beneficiaries more than this amount for covered services. Both network and non-network providers can seek applicable co-pays and cost-shares directly from the beneficiaries.

Non-network nonparticipating providers do not have to accept the TRICARE allowable charge and may bill patients for up to 15 percent above the TRICARE allowable charge. If the billed amount is less than the TRICARE allowable charge, TRICARE reimburses the billed amount.

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

Medicare's balance billing limitations apply to TRICARE. Noncompliance with balance billing requirements may affect a provider's TRICARE and/or Medicare status. Balance billing limitations only apply to TRICARE-covered services.

Providers may not bill beneficiaries for administrative expenses, including collection fees, to collect TRICARE payment. In addition, network and participating non-network providers cannot bill beneficiaries for noncovered services unless the beneficiary agrees in advance and in writing to pay for these services up front. At that point the provider is not obligated to file a claim to TRICARE if the TRICARE specific waiver is in place and the non-covered service is confirmed prior to the date of service.

Noncovered services

Before delivering care, network providers must verify the services are covered. Non-covered services may include:

- Services that appear on the No Government Pay Procedure Code List, available at ***TRICARE.mil/NoGovernmentPay***
- Services outside of the scope of TRICARE-covered services/benefits
- Services that currently have a temporary code or are still considered experimental

Note: ADSMs may be covered for the above noncovered services on a case-by-case basis as long as there is a valid authorization from their military hospital or clinic.

Once providers have verified the service needed/requested is truly "**noncovered**," the beneficiary must agree in advance and in writing to receive and accept financial responsibility for noncovered services. The agreement is the TRICARE noncovered waiver and must document the specific services, dates, estimated costs and other information.

Network providers must use the *TRICARE Noncovered Services Waiver* form to satisfy the requirements according to TRICARE policy. A general agreement to pay, such as one signed by the beneficiary at the time of their initial visit, is not sufficient to prove that a beneficiary was properly informed or agreed to pay for the specific noncovered service.

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

To download the form, search for **TRICARE noncovered services waiver** at **HumanaMilitary.com**. Network providers should keep copies of the *TRICARE Noncovered Services Waiver* form in their offices.

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

Hold-harmless policy for network providers

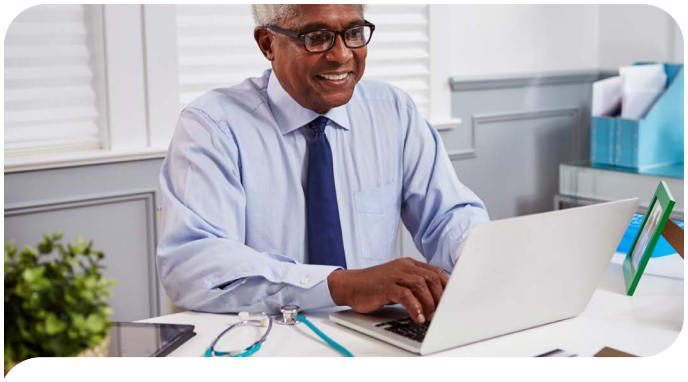
A network provider may not bill a TRICARE beneficiary for excluded or excludable services (i.e., the beneficiary is held harmless), except in the following circumstances:

- 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 via the noncovered service wavier

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

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

TRICARE network providers must file patients' claims for all covered services, even when the patient has Other Health Insurance (OHI).



An important message from TRICARE

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

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

To download the form, search for **important message** at **HumanaMilitary.com**

Clearly Legible Reports (CLRs)

For care referred by an military hospital or clinic, network providers must provide Clearly Legible Reports (CLRs), which include consultation reports, operative reports and discharge summaries to the military hospital or clinic within seven business days or a maximum of 10 calendar days from the time of care delivery. Mental health care network providers must submit brief initial assessments within seven to 10 business days.

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

Tips for returning CLRs

- Requested clearly legible consult reports must be returned on TRICARE patients within 10 days following the patient's appointment unless an urgent situation exists
- For urgent consults, contact the referring provider by phone within 24 hours, and follow up by faxing the formal consult report to the specified military hospital or clinic number within 10 days of the appointment date
- Remember to check the fax number periodically and confirm it is the correct fax number for consult reports
- If your office uses a transcription service that sends consult reports directly to the referring physician, please inform them of the fax number for TRICARE patient consults and the 10 day requirement
- Please be sure Humana Military is notified if you change your office or referral fax line in order ensure an accurate send for a referral/authorization confirmation

TRICARE program options

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

TRICARE Prime coverage options

TRICARE Prime, TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) are managed care options offering the most affordable and comprehensive coverage. While Active Duty Service Members (ADSMs) must enroll in a TRICARE Prime option, Active Duty Family Members (ADFMs), retirees and their families, and others may choose to enroll in TRICARE Prime or use TRICARE Standard/TRICARE Extra. ADSMs receive care at Military Treatment Facilities (military hospitals and clinics). If civilian network care is required, the military hospitals and clinics will provide a referral. Active Duty Service members cannot be treated outside of the military hospitals and clinics without a valid referral, including preventive services.

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

TRICARE Prime

TRICARE Prime is a managed care option available in TRICARE Prime Service Areas (PSAs). A PSA is a geographic area where TRICARE Prime benefits are offered. It is typically an area around a military hospital or clinic or other predetermined area.

ADFMs and other eligible beneficiaries may enroll in TRICARE Prime or use TRICARE Standard/TRICARE Extra. Each TRICARE Prime enrollee is assigned a Primary Care Manager (PCM).

Whenever possible, a PCM located at a military hospital or clinic is assigned, but a TRICARE network PCM may be assigned if a military hospital or clinic PCM is not available.

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

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

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

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

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

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

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

TPR ADSMs do not need referrals, prior authorizations or fitness-for-duty reviews to receive primary care. Specialty and inpatient services require referrals and prior authorizations from Humana Military/ValueOptions Federal Services 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 ***TRICARE.mil/TPRZipCode***

TRICARE Standard and TRICARE Extra

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

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

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

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

See the **health care management and administration** section or the **mental health care services** section for more information about referral and authorization requirements.

See the **TRICARE program options costs chart**, included with this handbook, for specific cost information. For more cost information, visit *TRICARE.mil/costs*

Supplemental Health Care Program (SHCP)

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

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

Only the following individuals are eligible for SHCP:

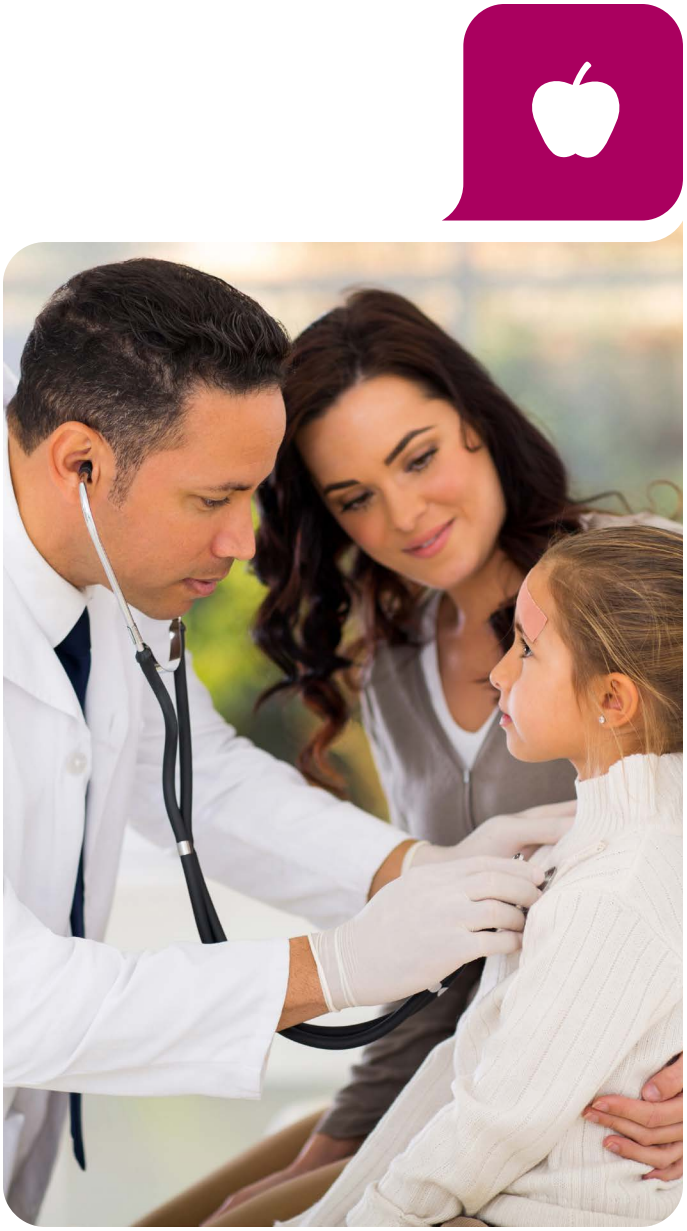
- ADSMs assigned to military hospitals or clinics
- ADSMs on travel status (e.g., leave, temporary assignment to duty or permanent change of station)
- Navy and Marine Corps service members enrolled to deployable units and referred by the unit PCM (non-military hospital or clinic)
- National Guard and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

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

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

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

SHCP beneficiaries are not responsible for cost-shares, co-pays or deductibles.



Medical coverage and healthcare management

Introduction

TRICARE beneficiaries are instructed to receive all routine care, when possible, from network providers in their designated regions.

TRICARE covers most medically necessary inpatient and outpatient care. This section provides an overview of the special rules and limits for TRICARE-covered benefits and services. The Specified Authorization Service (SAS) may authorize services for Active Duty Service Members (ADSMs) that are not regular TRICARE benefits. This overview is not all-inclusive. For additional details, visit **HumanaMilitary.com** or call **1-800-444-5445**.

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

In general, TRICARE excludes services and supplies 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.

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 by signing the TRICARE non-covered services waiver form.

To determine if a specific service is a covered benefit or if coverage is limited, check the current list of non-covered services on the No Government Pay Procedure Code List at *TRICARE.mil/NoGovernmentPay* or check the code look up using the secure **self-service for providers portal** at **HumanaMilitary.com**

The information contained in this section is not all-inclusive. See the **mental health care services** section for a list of mental health care limitations and exclusions.

Covered benefits and services

TRICARE covers most medically necessary inpatient and outpatient care. This chart provides an overview of the special rules and limits for TRICARE-covered benefits and services. This overview is **not** all-inclusive. For additional details visit **HumanaMilitary.com** or call **1-800-444-5445**.

Covered outpatient and inpatient services		
Service	Coverage details	Prior authorization requirements[1]
Adjunctive dental care	• Covered when medically necessary to treat a covered medical (not dental) condition, is an integral part of the treatment of such medical condition or is required in preparation for, or as the result of, dental trauma that may be or is caused by medically necessary treatment of an injury or disease • Acute anxiety, mental health issues, need for extensive treatment or need for sedation/anesthesia does not alone qualify a patient for adjunctive dental care coverage	• Required • Emergency adjunctive care does not require prior authorization
Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS	• Covers medical equipment or supplies needed by a patient in order to arrest or reduce functional loss • Must be ordered by a physician	• A prescription requesting DMEPOS signed by the beneficiary's physician is required for rental or purchase of DMEPOS. Prescriptions must specify the beneficiary's diagnosis, the particular type of equipment needed, the reason it is needed and the duration for which it will be needed. A Certificate of Medical Necessity (CMN) may be accepted in place of a prescription

The information contained in these charts is not all-inclusive.

Covered outpatient and inpatient services (continued)

Service	Coverage details	Prior authorization requirements[1]
Emergency care/urgent care	• Covered for qualified medical, maternity and psychiatric conditions • Ambulance services covered for emergency situations. Non-emergency medical transportation is only covered when provided by an ambulance service and is medically necessary in connection with otherwise covered services and supplies and a covered medical condition • Urgent care is not the same as emergency care but may be needed to treat a condition that doesn't threaten life, limb or eyesight but attention before it becomes a serious risk to health	• In all emergency situations, the TRICARE Prime beneficiary must notify his or her Primary Care Manager (PCM) or Humana Military of any emergency inpatient admission within 24 hours or the next business day so ongoing care can be coordinated. Requests for authorizations may be entered at **HumanaMilitary.com** or faxed to **1-877-548-1547** • TRICARE Prime beneficiaries must obtain referrals from their PCMs or Humana Military for urgent care. If a TRICARE Prime beneficiary does not receive a referral, the claim will be paid under the Point-Of-Service (POS) option
Home health care (provided by participating home health care agencies)	• Covers a limited number of hours per week of either part-time or intermittent services • Patient must be confined to the home and under the care of a physician • Urgent care is not the same as emergency care but may be needed to treat a condition that doesn't threaten life, limb or eyesight but attention before it becomes a serious risk to health • Respite care for ADSMs who are homebound as a result of a serious injury or illness incurred while serving on active duty may be covered if the ADSM's plan of care includes frequent interventions by the primary caregiver	• All home health services require prior authorization from Humana Military and must be renewed every 60 days • Home infusion has limited coverage. The type of medication used in home infusion determines whether the benefit will pay under the medical benefit or the pharmacy benefit • Prior authorization is required to ensure medications are received from the correct TRICARE source and any required nursing visits and DME are approved. • Prior authorization from Humana Military and the ADSM's approving authority for respite care for ADSM
Hospice care	• Provided in three benefit periods: • First two benefit periods: 90 days each, 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 • Final benefit period: Unlimited number of 60-day periods, each of which requires recertification of the terminal illness	• Required for all hospice care • If patient does not meet criteria for admission for hospice services, the provider cannot bill TRICARE
Hospitalization (semiprivate room/special care units when medically necessary)	• Covered services include: General nursing; hospital; physician and surgical services; meals (including special diets); drugs/medications; operating/recovery room care; anesthesia; laboratory tests; X-rays/other radiology services; medical supplies and appliances; and blood and blood products • Surgical procedures considered inpatient only may only be covered when performed in an inpatient setting • Semiprivate rooms and special care units may be covered if medically necessary	• Notify Humana Military of inpatient admission at **HumanaMilitary.com** or by faxing **1-877-548-1547** within 24 hours or the next business day
Maternity care	• Covers medical services related to prenatal care, labor and delivery and postpartum care • Eligible beneficiaries can receive maternity care from the first obstetric visit through up to six weeks after the birth of the child	• Required for obstetric (inpatient and outpatient) care for TRICARE Prime, TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) beneficiaries. (Obtain authorization at mother's first pregnancy-related appointment with the PCM or provider) • Maternity inpatient stays require additional prior authorization
Skilled Nursing Facility (SNF) care	• TRICARE-participating SNFs in semiprivate rooms for patients with qualifying medical conditions treated in hospitals for at least three consecutive days (not including the day of discharge) or if the patient is admitted to the SNF within 30 days of his or her discharge from the hospital	• All admissions or transfers to an SNF require prior authorization • TRICARE only covers care at Medicare-certified

The information contained in these charts is not all-inclusive.

Covered clinical preventive services

Service	Procedures and frequency limitations
Cancer screenings	**Colonoscopy:** Individuals at average risk for colon cancer are covered once every 10 years beginning at age 50. For individuals with increased risk, a colonoscopy is performed every two years beginning at age 25 or five years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier. Screenings are performed annually after age 40 for individuals with hereditary non-polyposis colorectal cancer syndrome. Individuals with familial risk of sporadic colorectal cancer (i.e., individuals with first-degree relatives with sporadic colorectal cancer or adenomas before age 60 or multiple first-degree relatives with colorectal cancer or adenomas) may receive a colonoscopy every three to five years beginning at an age 10 years earlier than the youngest affected relative. **Fecal Occult Blood Testing (FOBT):** Individuals are covered once every 12 months (either guaiac-based testing or immunochemical-based testing) beginning at age 50. At least 11 months must pass following the month of the last covered FOBT. **Mammograms:** Women over age 39 are covered for annual screening mammograms. High-risk women (i.e., family history of breast cancer in a first-degree relative) can receive a baseline mammogram at age 35 and then annually. **Magnetic Resonance Imaging (MRI) breast screenings:** Asymptomatic women age 30 or older considered to be at high risk of developing breast cancer per the guidelines of the American Cancer Society (ACS) may receive an MRI breast screening annually. These guidelines include women who meet one of the following conditions: • A known BRCA1 or BRCA2 gene mutation • A first-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation who have not had genetic testing themselves • History of radiation to the chest between the ages of 10 and 30 • History of Li-Fraumeni, Cowden or Hereditary Diffuse Gastric Cancer Syndrome or a first-degree relative with a history of one of these syndromes **Proctosigmoidoscopy or sigmoidoscopy:** Beneficiaries are covered once every three to five years beginning at age 50. **Prostate cancer:** All men are covered for an annual digital rectal examination beginning at age 50. Annual exams are also covered for men with a family history of prostate cancer in at least one other family member beginning at age 45, all African-American men regardless of family history beginning at age 45 and men with a family history of prostate cancer in two or more other family members beginning at age 40. An annual **Prostate Specific Antigen (PSA)** screening is covered for all men beginning at age 50, men with a family history of prostate cancer in at least one other family member beginning at age 45, all African-American men regardless of family history beginning at age 45 and men with a family history of prostate cancer in two or more other family members beginning at age 40. **Routine pap smears:** Women are covered annually beginning at age 18 (or younger if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may then decrease at the discretion of the patient and clinician, but not less frequently than every three years. **Skin cancer:** Individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions should receive regular skin examinations.
Cardiovascular	**Blood pressure screenings:** Children ages three to six should receive annual screenings. Children over age six and adults should receive screenings at a minimum of every two years. **Cholesterol test:** TRICARE covers age-specific periodic lipid panels as recommended by the National Heart, Lung and Blood Institute (NHLBI). Refer to NHLBI's website for current recommendations: ***nhlbi.nih.gov/health-pro/guidelines/current*** **Abdominal Aortic Aneurysm (AAA):** Men ages 65 to 75 who have ever smoked may receive a one-time AAA screening by ultrasonography.
Hearing	All high-risk neonates (as defined by the Joint Committee on Infant Hearing) should undergo audiology screening before leaving the hospital. If not tested at birth, high-risk children should be screened before three months of age. Evaluate hearing of all children as part of routine examinations, and refer those with possible hearing impairment as appropriate.

The information contained in these charts is not all-inclusive.

Covered clinical preventive services (continued)	
Service	Procedures and frequency limitations
Immunizations	TRICARE covers age-appropriate doses of vaccines recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) and accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC Morbidity and Mortality Weekly Report (MMWR). Refer to the CDC's website for the current schedule of CDC-recommended vaccines: ***CDC.gov*** Immunizations required for ADFMs whose sponsors have permanent change of station orders to overseas locations are also covered.
Infectious disease screening	**Tuberculosis screening:** TRICARE covers annual screenings, regardless of age, for all high-risk individuals (as defined by CDC) using Mantoux tests. **Rubella antibodies:** TRICARE covers a one-time screening for females ages 12 to 18, unless there's a documented history of adequate rubella vaccination with at least one dose of rubella vaccine on or after the first birthday. **Hepatitis B screening:** Screen pregnant women for HBsAG during the prenatal period.
Vision coverage	TRICARE may cover routine and comprehensive eye exams not related to another medical or surgical condition. Vision coverage varies based on beneficiary status, program option and age.
Other	**Pediatric blood lead:** TRICARE covers assessment of risk for lead exposure by structured questionnaire based on the CDC's Preventing Lead Poisoning in Young Children (October 1991) during each well-child visit from age six months through six years. TRICARE covers screenings by blood lead level determination for all children at high risk for lead exposure per CDC guidelines.

The information contained in these charts is not all-inclusive.

Maternity care

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

Eligibility

- TRICARE covers maternity care for a TRICARE-eligible dependent daughter of an ADSM or retired service member
- TRICARE does not cover care for the newborn grandchild unless the newborn is otherwise eligible as an adopted child or the child of another eligible sponsor
- A newborn is covered as a TRICARE Prime or TPR beneficiary for the first 60 days following birth or adoption as long as one additional family member is enrolled in TRICARE Prime or TPR. If the child is not enrolled in TRICARE Prime or TPR within 60 days, coverage will revert to the TRICARE Standard program option

Coverage

- Maternity care includes medical services related to prenatal care, labor and delivery, and postpartum care
- TRICARE covers professional and technical components of medically necessary fetal ultrasounds as well as the maternity global fee
- A maternal ultrasound is covered only with diagnosis and management of conditions that constitute a high-risk pregnancy
- TRICARE does not cover ultrasounds for routine screening or to determine the sex of the baby
- In the absence of other qualifying conditions, pain associated with pregnancy or incipient birth after the 34th week of gestation when associated with a pregnancy is not an emergency condition for adjudication purposes

Referral and authorization requriements

- The PCM for a beneficiary who becomes pregnant must submit a referral request prior to the mother's first pregnancy-related appointment with an obstetrician
- The referral begins with the first prenatal visit and remains valid until 42 days after birth
- Prior to the delivery, the PCM must obtain a prior authorization for the civilian (non-military hospital or clinic) inpatient facility or birthing center where the beneficiary plans to deliver
- The inpatient length of stay cannot be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section
- Notify Humana Military if the mother is hospitalized or placed in observation during the pregnancy for any reason other than delivery
- If a newborn remains in the hospital after the mother is discharged, a separate inpatient authorization is required for the newborn

Home health care

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

Assistance with daily living activities (e.g., laundry, cleaning dishes, etc.) is not part of the home health care benefit.

Respite care for ADSMs who are homebound as a result of a serious injury or illness incurred while serving on active duty may be covered if the ADSM's plan of care includes frequent interventions by the primary caregiver. It requires prior authorization from Humana Military and the ADSM's approving authority (i.e., MMSO or the referring military hospital or clinic).

Refer to the TRICARE manuals at ***manuals.TRICARE.osd.mil***

For information about home health care, refer to the *TRICARE Reimbursement Manual*, chapter 12.

For information about home health care benefits related to the TRICARE ECHO program, refer to the *TRICARE Policy Manual*, chapter 9, section 15.1.

For information about ADSM respite care coverage, refer to the *TRICARE Operations Manual*, chapter 18, section 3 and addendum c.

Infusion therapy

Infusion therapy delivered in the home may include:

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

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

For information about home infusion benefits, refer to the *TRICARE Policy Manual*, chapter 8, section 20.1. at ***manuals.TRICARE.osd.mil***

Hospitalization

TRICARE covers hospitalization services, including general nursing; hospital, physician and surgical services; meals (including special diets); drugs and medications; operating and recovery room care; anesthesia; laboratory tests; X-rays and other radiology services; medical supplies and appliances; and blood and blood products. TRICARE may cover semiprivate rooms and special care units if medically necessary. TRICARE may only cover surgical procedures designated as "inpatient only" when performed in an inpatient setting.

Skilled Nursing Facility (SNF) care

All admissions or transfers to a SNF require prior authorization. TRICARE only covers care at Medicare-certified, TRICARE-participating SNFs in semiprivate rooms for patients with qualifying medical conditions treated in hospitals for at least three consecutive days (not including the day of discharge) or if the patient is admitted to the SNF within 30 days of his or her discharge from the hospital.

Hospice care

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

For more information about TRICARE's hospice coverage, refer to the *TRICARE Reimbursement Manual*, chapter 11 at ***manuals.TRICARE.osd.mil***

Laboratory and x-ray services

TRICARE generally covers laboratory and X-ray services if prescribed by a physician. However, some exceptions apply (e.g., chemo-sensitivity assays, bone density X-ray studies for routine osteoporosis screening).The TRICARE demonstration project for approved Laboratory Developed Tests (LDTs)is covered for TRICARE beneficiaries (including ADSMs). These tests may require prior authorization. For more information, search for **genetic testing** at **HumanaMilitary.com** (See chart below)

Guidelines for Laboratory Developed Test (LDT)

LDT	Specific codes	Covered for the following:
ALK	88271 88291	• To determine response to Tyrosine Kinase Inhibitor (TKI) therapy in patients with adenocarcinoma of the lung or mixed lung cancer with adenocarcinoma component of the lung.
ATXN1	81401	• Diagnosis of Spinocerebellar Ataxia Type 1 (SCA1) in patients with cerebellar ataxia of unknown etiology, along with extracerebellar symptoms associated with SCA1 and/or a family history consistent with autosomal dominant inheritance. • Diagnosis of SCA1 in symptomatic family members of known SCA1 patients.

Laboratories performing LDTs must have CLIA accreditation or certificate of compliance.

Guidelines for Laboratory Developed Test (LDT)

LDT	Specific codes	Covered for the following:
ATXN2	81401	• Diagnosis of Spinocerebellar Ataxia Type 2 (SCA2) in patients with cerebellar ataxia of unknown etiology, along with extracerebellar symptoms associated with SCA2 and/or a family history consistent with autosomal dominant inheritance. • Diagnosis of SCA2 in symptomatic family members of known SCA2 patients.
ATXN3	81401	• Diagnosis of Spinocerebellar Ataxia Type 3 (SCA3) in patients with cerebellar ataxia of unknown etiology, along with extracerebellar symptoms associated with SCA3 and/or a family history consistent with autosomal dominant inheritance. • Diagnosis of SCA3 in symptomatic family members of known SCA3 patients.
ATXN7	81401	• Diagnosis of Spinocerebellar Ataxia Type 7 (SCA7) in patients with cerebellar ataxia and visual disturbance. • Diagnosis of SCA7 in symptomatic family members of known SCA7 patients.
ATXN10	81401	• Diagnosis of Spinocerebellar Ataxia Type 10 (SCA10) in ataxia patients whose ancestry is of American Indian origin, and whose family history is consistent with autosomal dominant inheritance. • Diagnosis of SCA10 in symptomatic family members of known SCA10 patients.
BCR/ABL1	81206 81207 81208	• Diagnostic assessment of patients with suspected Chronic Myelogenous Leukemia (CML) by quantitative RT-PCR (RQ-PCR). • Diagnostic assessment of patients with suspected CML by qualitative RT-PCR. • Monitoring response to TKI therapy, such as imatinib, in patients with CML by RQ-PCR. • Testing for the presence of the BCR/ABL1 p.Thr315Ile variant in CML patients to guide treatment selection following resistance to first-line imatinib therapy. • Testing for the presence of BCR/ABL1 variants other than p.Thr315Ile in CML patients to guide treatment selection following resistance to first-line imatinib therapy.
BMPR1A	81479	• To clarify the diagnosis of patients with Juvenile Polyposis Syndrome (JPS). • If a known SMAD4 mutation is in the family, genetic testing should be performed in the first six months of life due to hereditary hemorrhagic telangiectasia risk.
BRAF	81210 81406	• To predict response to vemurafenib therapy in patients with a positive cobas 4800 BRAF mutation test result. • For patients with indeterminate thyroid Fine-Needle Aspiration (FNA) biopsy cytology for diagnosis of papillary thyroid carcinoma.

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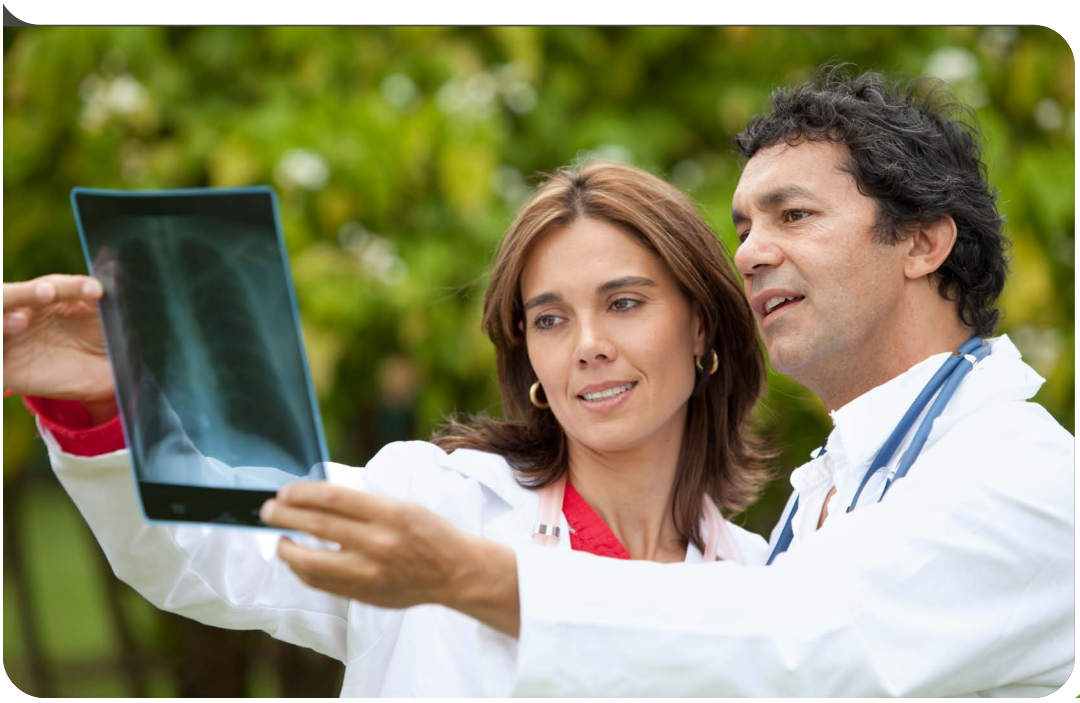


Guidelines for Laboratory Developed Test (LDT) (continued)

LDT	Specific codes	Covered for the following:

BRCA analysis BRCA1/BRCA 2	81211
	81212
	81213 (not covered as a stand alone test)
	81214
	81215
	81216
	81217
		• Patient from families transmitting a known BRCA1/2 variant
		• Patient with a history breast cancer and at least one of the following:
		  • Breast cancer diagnosed ≤ 45 years of age
		  • Breast cancer diagnosed ≤ 50 years of age and a close family member with breast cancer ≤ 45 years of age or ovarian cancer at any age
		• Two breast primaries with one diagnosed at or before age 50
		• A diagnosis of triple negative breast cancer at or before age 60
		• Breast cancer diagnosed at any age and at least one close relative with breast cancer before age 50 and/or epithelial ovarian cancer at any age
		• Breast cancer diagnosed at any age and at least two close relatives diagnosed with breast, pancreatic and/or prostate (Gleason ≥ 7) cancer at any age
		• A close male relative with breast cancer
		• An ethnic background associated with a higher frequency of BRCA1/2 variants (i.e., Ashkenazi Jewish)
		• Patient with a personal history of epithelial ovarian cancer
		• Patient with male breast cancer.
		• Patient with a personal history of pancreatic or prostate (Gleason ≥ 7) cancer and at least two close relatives with breast, ovarian, prostate (Gleason ≥ 7) and/or pancreatic cancer.
		• Unaffected patient (with no personal history of cancer) who have one of the following:
		  • A first or second-degree relative satisfying the above criteria
		  • A third-degree relative with breast and/or ovarian cancer and at least two more relatives with breast cancer (at least one diagnosed before age 50) and/or ovarian cancer.
		
		Note: One must have 3 relatives with breast or ovarian cancer. One must be a third degree relative (A third-degree relative is defined as a blood relative which includes the individual's first-cousins, great-grandparents or great grandchildren). The other two may be more distantly related with breast or ovarian cancer. If the other two include breast cancer, one breast cancer patient must have been diagnosed before 50. The words "at least one diagnosed before age 50" apply to "two or more relatives" who have had breast cancer.
		
		Detection of large genomic rearrangements (e.g., BRACAnalysis® Large Rearrangement Test (BART)) is considered medically necessary for patients who meet the testing criteria for BRCA1/BRCA2, have no known familial BRCA1/BRCA2 mutations, and the original BRACAnalysis® test was negative. BART is not covered as a stand-alone test.

CACNA1A	81401	• Diagnosis of Spinocerebellar Ataxia Type 6 (SCA6) in patients with cerebellar ataxia with dysarthria and/or nystagmus. • Diagnosis of SCA6 in symptomatic family members of known SCA6 patients.
CEBPA	81403	• To guide the treatment decisions for patients with Acute Myeloid Leukemia (AML).
Chromosome 22q11.2	88271 88291	• Confirmation of diagnosis in an individual suspected of chromosome 22q11.2 deletion syndrome based on clinical findings.
CF testing (Cystic Fibrosis)	81220 81221 81222 81223 81224	• As part of a newborn screening panel included in well-child care (*TRICARE Policy Manual* chapter 7, section 2.5) - handled under the authorization for the delivery. It does not require a separate authorization.
CFTR (Cystic Fibrosis)	81220 81221 81222 81223 81224	• Confirmation of diagnosis in patients showing clinical symptoms of Cystic Fibrosis (CF) or having a high sweat chloride level. • Identification of newborns who are affected with CF. • Identification of patients with the p.Gly551Asp variant who will respond to treatment with ivacaftor. • Male infertility testing and treatment. • Preconception and prenatal carrier screening in accordance with the most current ACOG guidelines
COL3A1	81479	To confirm or establish a diagnosis of Ehlers-Danlos Syndrome Type 4 (EDS IV), also known as vascular EDS, in patients with clinical symptoms or features of EDS IV.
CYP2C19	81225	To manage dosing of clopidogrel.

Laboratories performing LDTs must have CLIA accreditation or certificate of compliance.

Guidelines for Laboratory Developed Test (LDT) (continued)

LDT	Specific codes	Covered for the following:
Colaris® for Lynch syndrome **MLH1, MSH2, MSH6, MSI, PMS2, and EPCAM**	81292 81293 81294 81295 81296 81297 81298 81299 81300 81301 81317 81318 81319 81403	Patient who has or has had colorectal or endometrial cancer and meets one of the following criteria: 1. Amsterdam II criteria for Lynch syndrome genetic testing. At least three relatives of the affected patientficiary must have a cancer associated with Lynch syndrome; and all of the following criteria must be present: • One must be a first-degree relative of the other two • At least two successive generations must be affected • At least one relative with cancer associated with Lynch syndrome should be diagnosed before the age 50 years • Familial Adenomatous Polyposis (FAP) should be excluded in the colorectal cancer case(s) (if any) • Tumors should be verified whenever possible. 2. Revised Bethesda guidelines: • Colorectal cancer diagnosed in a patientficiary at less than 50 years of age. • Presence of synchronous or metachronous Lynch syndrome-associated cancers,regardless of age. Lynch syndrome-associated cancers include colorectal, endometrial, ovarian, gastric, pancreas, ureter and renal pelvis, biliary tract, brain (usually glioblastoma), and small intestine cancers, as well as sebaceous gland adenomas/carcinomas and keratoacanthomas • Colorectal cancer with the MSI-H histology diagnosed in a patientficiary who is less than 60 years of age. • Colorectal cancer diagnosed in a patientficiary with one or more first-degree relatives with a Lynch syndrome-associated cancer, with one of the cancers being diagnosed under age 50 years. • Colorectal cancer diagnosed in a patientficiary with two or more first or second-degree relatives with Lynch syndrome-associated cancers, regardless of age. 3. Patient has a known Lynch syndrome in the family. 4. Endometrial cancer diagnosed in a patient at less than 50 years of age. 5. If any of the revised Bethesda guidelines are met, Microsatellite Instability (MSI) and/or Immunohistochemistry (IHC) testing on the colon cancer tissue may be clinically appropriate. If the tumor is MSI positive or mutation of one of the mismatch repair genes is indicated by failure of IHC staining, then genetic testing should be undertaken. Further unnecessary testing can often be avoided by performance of IHC prior to any MSI testing. Colaris® testing is covered for symptomatic or asymptomatic patients > 18 years of age who are at risk of having a known familial sequence variant in a Mismatch Repair (MMR) gene.
Colaris AP® for detection mutations in the APC and MUTYH-MYH genes	81201 81202 81203 81401 81403 81406	Colaris AP testing is not covered for prenatal diagnosis or Pre-implantation Genetic Diagnosis (PGD) in couples affected with, or at-risk for FAP. Other than prenatal diagnosis or PGD, testing is covered: • For genetic testing for APC variants in patients with clinical symptoms consistent with FAP. • For genetic testing for APC variants in patients with clinical symptoms consistent with AFAP. • For genetic testing for APC variants in patients with clinical symptoms consistent with Turcot's or Gardner's syndromes. • For testing patients with an APC-associated polyposis syndrome for the purpose of identifying a variant that may be used to screen at-risk relatives. • For the presymptomatic testing of at-risk relatives for a known familial variant. • **Not covered** for prenatal testing or PGD in couples at risk for FAP. MYH gene testing may be performed in patients with colorectal polyposis of unknown etiology, and in the siblings and offspring of known MYH-Associated Polyposis (MAP) patients: • For the diagnosis of MAP in APC-negative polyposis patients, or in polyposis patients who have a family history consistent with autosomal recessive inheritance. • For the diagnosis of MAP in asymptomatic siblings of patients with known MYH variants. • For the testing of offspring or asymptomatic siblings of known MAP patients in order to provide an accurate recurrence risk to offspring.

Laboratories performing LDTs must have CLIA accreditation or certificate of compliance.

Guidelines for Laboratory Developed Test (LDT) (continued)

LDT	Specific codes	Covered for the following:
Cytogenomic Constitutional Microarray Analysis (CCMA)	81228 81229 81406	• Diagnostic evaluation of patients suspected of having a genetic syndrome (i.e., have congenital anomalies, dysmorphic features, Developmental Delay (DD) and/or intellectual disability). • Diagnostic evaluation of patients with Autism Spectrum Disorder (ASD), including autism, Asperger syndrome and pervasive developmental disorder.
DAZ/SRY	81408	• To detect submicroscopic deletions involving the Y chromosome in the evaluation of men with infertility secondary to azoospermia, oligozoospermia or teratozoospermia.
DMD	81408	• For diagnostic DMD testing (deletion and duplication analysis with reflex to complete gene sequencing) in males or females exhibiting symptoms of Duchenne Muscular Dystrophy (DMD) or Becker Muscular Dystrophy (BMD).
DMPK	81401 81404	• Confirmation of a diagnosis of Myotonic Dystrophy Type 1 (DM1) or Type 2 (DM2) in symptomatic patients. • Diagnosis of DM1 or DM2 in asymptomatic adults who are at an increased risk of DM1 or DM2 through a positive family history.
EGFR	81235	• To help guide administration of Epidermal Growth Factor Receptor (EGFR) TKIs in the first-line treatment of non-small cell lung cancer.
F2	81240 81400	• Diagnostic evaluation of patients with a prior Venous Thromboembolism (VTE) during pregnancy or puerperium. • For patients with VTE with a personal or family history of recurrent VTE (more than two in the same person). • For patients with their first VTE before age 50 with no precipitating factors. • For venous thrombosis at unusual sites such as the cerebral, mesenteric, portal, or hepatic veins. • For VTE associated with the use of estrogen-containing oral contraceptives, Selective Estrogen Receptor Modulators (SERMs), or Hormone Replacement Therapy (HRT). • To diagnose an inherited thrombophilia in female family members of patients with an inherited thrombophilia if the female family member is pregnant or considering pregnancy or oral contraceptive use.
F5	81241 81240	• Diagnostic evaluation of patients with a prior VTE during pregnancy or puerperium. • For patients with VTE with a personal or family history of recurrent VTE (more than two in the same person). • For patients with their first VTE before age 50 with no precipitating factors. • For venous thrombosis at unusual sites such as the cerebral, mesenteric, portal, or hepatic veins. • For VTE associated with the use of estrogen-containing oral contraceptives, Selective Estrogen Receptor Modulators (SERMs), or Hormone Replacement Therapy (HRT). • To diagnose an inherited thrombophilia in female family members of patients with an inherited thrombophilia if the female family member is pregnant or considering pregnancy or oral contraceptive use.
FBN1	81408	• To facilitate the diagnosis of Marfan syndrome in patients who do not fulfill the Ghent diagnostic criteria, but have at least one major feature of the condition. • To facilitate the diagnosis of Marfan syndrome in the at-risk relatives of patients carrying known disease-causing variants.

FMR1	81243
	81244
		• FMR1 gene testing is covered for the following indications:
		  • Testing for CGG repeat length for diagnosis of patients of either sex with mental retardation, intellectual disability, developmental delay, or autism.
		• FMR1 gene testing for Fragile X-Associated Tremor/Ataxia Syndrome is covered for the following individuals:
		  • Males and females older than age 50 years who have progressive cerebellar ataxia and intention tremor with or without a positive family history of FMR1-related disorders in whom other common causes of ataxia have been excluded.
		  • Women with unexplained Premature Ovarian Insufficiency (POI).

GCK	81406	• Diagnosis of Maturity-Onset Diabetes of the Young Type 2 (MODY2) in patients with hyperglycemia or non-insulin-dependent diabetes who have a family history of abnormal glucose metabolism in at least two consecutive generations, with the patient or ≥ 1 family member(s) diagnosed before age 25.
GJB2	81252 81253	• Diagnosis of DFNB1 or DFNA3 in individuals with nonsyndromic hearing loss to aid in treatment.
GJB6	81254	• Diagnosis of DFNB1 or DFNA3 in individuals with nonsyndromic hearing loss to aid in treatment.

Laboratories performing LDTs must have CLIA accreditation or certificate of compliance.

Guidelines for Laboratory Developed Test (LDT) (continued)

LDT	Specific codes	Covered for the following:
HBA1/HBA2	81257 81404 81405	• To confirm the diagnosis of alpha-thalassemia in a symptomatic patient. • To confirm the diagnosis in a pregnant woman with low hemoglobin when alpha-thalassemia is suspected.
HEXA	81255 81406	• As an adjunct to biochemical testing in patients with low hexosaminidase A levels in blood. When patients are identified with apparent deficiency of hexosaminidase A enzymatic activity, targeted mutation analysis can then be used to distinguish pseudodeficiency alleles from disease-causing alleles.
HFE	81256	• Diagnosis of patients with or without symptoms of iron overload with a serum transferrin saturation >45% and/or elevated serum ferritin.
HFN1A	81405	• Diagnosis of Maturity-Onset Diabetes of the Young Type 3 (MODY3) in patients with hyperglycemia or non-insulin-dependent diabetes who have a family history of abnormal glucose metabolism in at least two consecutive generations, with the patient or ≥ 1 family member(s) diagnosed before age 25.
HLA	81370 81371 81372 81373 81374 81375 81376 81377 81378 81379 81380 81381 81382 81383	• To determine histocompatibility of tissue between organ and bone marrow donors and recipients prior to transplant. • For platelet transfusion for patients refractory to treatment due to alloimmunization. • Diagnosis of celiac disease in symptomatic patients with equivocal results on small bowel biopsy and serology, or in previously symptomatic patients who are asymptomatic while on a gluten-free diet. • Testing for the HLA-B*1502 allele prior to initiating treatment with carbamazepine in patients from high-risk ethnic groups. • Testing for the HLA-B*5701 allele for hypersensitivity reactions in patients prior to initiation or re-initiation with treatments containing abacavir. • Testing for the HLA-B*58:01 allele in patients prior to initiating treatment with allopurinol.
HTT	81401	• To test for CAG repeat length for diagnosis of Huntington Chorea/Disease (HD) inpatients suspected of having HD in the absence of a family history of HD.
JAK2	81270 81403	• Diagnostic evaluation of patients presenting with clinical, laboratory, or pathological findings suggesting classic forms of myeloproliferative neoplasms (MPN), that is, Polycythemia Vera (PV), Essential Thrombocythemia (ET) or Primary Myelofibrosis (PMF). • Diagnostic evaluation of PV through JAK2 Exon 12 variant detection in JAK2 p.Val617Phe negative patients.
KCNQ1, KCNH2, SCN5A, KCNE1, KCNE1	81280 81281 81282	• For patients with suspected familial Long QT Syndrome for confirmation of diagnosis and treatment.
KIT	81404	• To confirm a diagnosis of a gastrointestinal stromal tumor (GIST) in patients who are negative by immunostaining. • To determine primary resistance to treatment with TKIs in patients with an advanced metastatic or unresectable GIST. • To determine primary resistance to preoperative or postoperative treatment of a GIST with TKIs.
KRAS	81275	• To help guide administration of anti-EGFR monoclonal antibodies.
MECP2	81302 81303 81304	• Testing for MECP2 sequence variants in patients who meet established clinical diagnostic criteria for classic or variant Rett Syndrome (RS). • Testing for MECP2 sequence variants in patients who have symptoms of RS, but do not meet established clinical diagnostic criteria.
MPL	81402 81403	• Diagnostic evaluation of Myeloproliferative Leukemia (MPL) variants to include Trp515Leu and Trp515Lys in JAK2 p.Val617Phe-negative patients showing symptoms.
NPM1	81310	• To guide treatment decisions for patients with AML.
NRAS	81404	• For patients with metastatic colorectal cancer who are being considered for treatment with anti-EGFR monoclonal antibodies, and who have had negative KRAS gene testing.

Laboratories performing LDTs must have CLIA accreditation or certificate of compliance.

Guidelines for Laboratory Developed Test (LDT) (continued)

LDT	Specific codes	Covered for the following:
Oncotype DX® Breast Cancer Assay (Oncotype DX®)	S3854 81479 81519	• Estrogen Receptor (ER) positive (+), lymph node (LN) negative (-), human EGFR 2 negative (HER2-) breast cancer patients who are considering whether to use adjuvant chemotherapy in addition to standard hormone therapy. • ER+, HER2-breast cancer patients with 1-3 involved ipsilateral axillary lymph nodes who are considering whether to use adjuvant chemotherapy in addition to hormonal therapy.
PAX8	81401	• For patients with indeterminate thyroid FNA biopsy cytology for diagnosis of papillary thyroid carcinoma.
PDGFRA	81404	• To confirm a diagnosis of a GIST in patients who are negative by immunostaining. • To determine primary resistance to treatment with TKIs in patients with an advanced metastatic or unresectable GIST. • To determine primary resistance to preoperative or postoperative treatment of a GIST with TKIs.
PML/RARalpha	81315 81316	• Diagnostic assessment of patients with suspected acute promyelocytic leukemia (APL) by quantitative RT-PCR (RQ-PCR). • Diagnostic assessment of patients with suspected APL by qualitative RT-PCR. • Monitoring response to treatment and disease progression in patients with APL by RQ-PCR.
PMP22	81324 81325 81326	• For the accurate diagnosis and classification of hereditary polyneuropathies.
PPP2R2B	81401	• Diagnosis of Spinocerebellar Ataxia Type 12 (SCA12) in patients with action tremor of the upper extremities and signs of cerebellar and cortical dysfunction, in addition to Indian ancestry and a family history consistent with autosomal dominant inheritance. • Diagnosis of SCA12 in symptomatic family members of known SCA12 patients.

PRSS1	81401	• To confirm a diagnosis of hereditary pancreatitis in symptomatic patients with any of the following:
		  • A family history of pancreatitis in a first-degree (parent, sibling, child) or second-degree (aunt, uncle, grandparent) relative
		  • An unexplained episode of documented pancreatitis occurring in a child that has required hospitalization, and where there is significant concern that hereditary pancreatitis should be excluded
		  • Recurrent (two or more separate, documented episodes with hyper-amylasemia) attacks of acute pancreatitis for which there is no explanation (anatomical anomalies, ampullary or main pancreatic strictures, trauma, viral infection, gallstones, alcohol, drugs, hyperlipidemia, etc.)
		  • Unexplained (idiopathic) chronic pancreatitis.

PTEN	81321 81322 81323	• For patients with ASDs and macrocephaly (Head circumference greater than 2 standard above the mean for age). • PTEN variant testing in patients suspected of being affected with Cowden Syndrome (CS) or Bannayan-Riley-Ruvalcaba Syndrome (BRRS).
RET	81404 81405	• Multiple endocrine neoplasia type 2 (MEN2) gene testing in patients with the clinical manifestations of MEN2A, MEN2B, or familial medullary thyroid carcinoma (FMTC), including those with apparently sporadic Medullary Thyroid Carcinoma (MTC) or pheochromocytoma. • MEN2 gene testing to confirm a diagnosis in the at-risk relatives of genetically confirmed MEN2 patients.
RYR1	81408	• To test clinically confirmed Malignant Hyperthermia Susceptibility (MHS) patients for variants in the RYR1 gene to facilitate diagnostic testing in at-risk relatives. • To diagnose MHS in at-risk relatives of patients with clinically confirmed MHS.
SDHB	81405	• To diagnose a hereditary paraganglioma (PGL) or pheochromocytoma (PCC) syndrome in patients with PGLs and/or PCCs.
SDHD	81404	• To diagnose a hereditary PGL or PCC syndrome in patients with PGLs and/or PCCs.
SMAD4	81405 81406	• To clarify the diagnosis of patients with JPS. • If a known SMAD4 mutation is in the family, genetic testing should be performed in the first six months of life due to hereditary hemorrhagic telangiectasia risk.
SMN1/SMN2	81400 81401 81403 81405	• Diagnosis of patients with hypotonia and muscle weakness who are suspected of having Spinal Muscular Atrophy (SMA).

Laboratories performing LDTs must have CLIA accreditation or certificate of compliance.

Guidelines for Laboratory Developed Test (LDT) (continued)

LDT	Specific codes	Covered for the following:

SNRPN/UBE3A	81331	• When a clinical diagnosis of Prader-Willi Syndrome (PWS) is suspected, the following findings justify genetic testing:
		  • From birth to age two: Hypotonia with poor suck (neonatal period).
		  • From age two to age six: Hypotonia with history of poor suck, global developmental delay.
		  • From age six to age 12: Hypotonia with history of poor suck, global developmental delay, excessive eating with central obesity if uncontrolled.
		  • From age 13 years to adulthood: Cognitive impairment, usually mild intellectual disability; excessive eating with central obesity if uncontrolled, hypothalamic hypogonadism and/or typical behavior problems.
		• When a clinical diagnosis of Angelman Syndrome is suspected, the following findings justify genetic testing:
		  • As part of the evaluation of patients with developmental delay, regardless of age.
		  • As part of the evaluation of patients with a balance or movement disorder such as ataxia of gait. May not appear as frank ataxia but can be forward lurching, unsteadiness, clumsiness, or quick, jerky motions.
		  • As part of the evaluation of patients with uniqueness of behavior: any combination of frequent laughter/smiling; apparent happy demeanor; easily excitable personality, often with uplifted hand-flapping or waving movements; hypermotoric behavior.
		  • Speech impairment, none or minimal use of words; receptive and non-verbal communication skills higher than verbal ones.

STK11	81404 81405	• To confirm a diagnosis of Peutz-Jeghers Syndrome (PJS) in proband patients with a presumptive or probable diagnosis of PJS.
TBP	81401	• Diagnosis of Spinocerebellar Ataxia Type 17 (SCA17) in ataxia patients exhibiting variable combinations of cognitive decline, psychiatric disturbance and movement disorders. • Diagnosis of SCA17 in symptomatic family members of known SCA17 patients. • Diagnosis of SCA17 in patients suspected of having Huntington Disease (HD) who have tested negative for a pathogenic variant in the HD gene.
TP53	81404 81405	• Diagnosis of patients satisfying the criteria for classic Li-Fraumeni Syndrome (LFS) or Li-Fraumeni-Like Syndrome (LFLS), or the Chompret criteria for TP53 gene testing.
TRG	81342	• Diagnosis and treatment of T-cell neoplasms.
UPD	81402	• For neonates, infants, children or adults symptomatic for Beckwith-Wiedermann Syndrome (BWS) to diagnose Uniparental Disomy (UPD) for chromosome 11.
UGT1A1	81350	• Prior to irinotecan administration in patients with CRC to lower the starting dose of irinotecan in patients with the UGT1A1*28/UGT1A1*28 genotype. • Prior to irinotecan administration in patients with CRC to increase the starting dose of irinotecan in patients with the UGT1A1*1/UGT1A1*1 or UGT1A1*1/UGT1A1*28 genotypes.
VHL	81403 81404	• Diagnosis of Von Hippel-Lindau (VHL) syndrome in patients presenting with pheochromocytoma, paraganglioma, or central nervous system hemangioblastoma. • Confirmation of diagnosis in patients with symptoms consistent with VHL syndrome.

Laboratories performing LDTs must have CLIA accreditation or certificate of compliance.

Referrals and prior authorizations

Humana Military issues a referral when a TRICARE Prime beneficiary needs specialized medical services from a civilian professional or ancillary provider only if the requested services are not available at a military hospital/clinic or at the Primary Care Manager's (PCM's) office.

A prior authorization is issued for requested services, procedures or admissions that require medical necessity review prior to services being rendered.

Referral and authorization submission options

Submit online for quickest response via the **self-service for providers portal** at **HumanaMilitary.com**

Fax patient referral authorization form
1-877-548-1547

Submit by phone
1-800-444-5445

Mental health care referrals and authorizations via the **self-service for providers portal** at **HumanaMilitary.com**

Fax Outpatient Treatment Report (OTR): **1-866-811-4422**

For questions: **1-800-700-8646**

TRICARE Prime Point-Of-Service (POS) option

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

The POS cost-share applies when:

- The patient receives care from a civilian TRICARE-authorized provider without an appropriate referral/authorization
- The patient self-refers to a network specialty care provider after Humana Military authorizes a referral to see a military hospital or clinic specialty care provider
- The patient enrolled at a military hospital or clinic self-refers to a civilian provider, other than his or her PCM, for routine care
- The patient self-refers for non-emergency mental health care from a non-network behavioral provider. (The POS option applies to all non-emergency mental health care from non-network providers. Prior authorization requirements may still apply.)

The POS option does not apply to the following:

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

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

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

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

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

TRICARE for Life (TFL)

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

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

- ADFMs remain eligible for TRICARE Prime and TRICARE Standard/ TRICARE Extra while the sponsor is on active duty. However, once the sponsor retires from active duty, the sponsor and his or her family members who are entitled to premium-free Medicare Part A must also have Medicare Part B to keep their TRICARE benefits.
- TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), CHCBP and US Family Health Plan (USFHP) beneficiaries are not required to have Medicare Part B to remain covered under these programs.
- **Note:** TRICARE advises beneficiaries to sign up for Medicare Part B when first eligible to avoid a break in TRICARE coverage. Beneficiaries who sign up later may have to pay a premium surcharge for as long as they have Part B. The Medicare Part B surcharge is 10 percent for each 12-month period that a beneficiary was eligible to enroll in Part B but did not enroll.
- After turning 65, beneficiaries who are not eligible for premium-free Medicare Part A on their own or their current, former or deceased spouse's record may remain eligible for TRICARE Prime or TRICARE Standard/TRICARE Extra. They must take the Notices of Award and/or Notices of Disapproved Claim they received from the Social Security Administration (SSA) to the nearest uniformed services ID card-issuing facility to update DEERS and get new ID cards.
- Beneficiaries who receive disability benefits from the SSA are entitled to Medicare in the 25th month of receiving disability payments. The Centers for Medicare and Medicaid Services (CMS) notifies beneficiaries of their Medicare entitlement date.

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

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

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

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

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

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

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

TFL beneficiaries must present valid uniformed services identification (ID) cards and Medicare cards prior to receiving services. If a TFL beneficiary's uniformed services ID card reads "**no**" under the civilian box, he or she is still eligible to use TFL if he or she has both Medicare Part A and Part B. Copy both sides of the cards and retain the copies for files.

There is no separate TFL enrollment card. To verify TFL eligibility, call the TFL contractor, Wisconsin Physicians Service/TRICARE Dual Eligible Fiscal Intermediary Contract (WPS/TDEFIC), at **1-866-773-0404**. Call the Social Security Administration (SSA) at **1-800-772-1213** to confirm a patient's Medicare status.

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

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

How TRICARE for Life works

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

File TFL claims first with Medicare. Medicare pays its portion and electronically forwards the claim to WPS/TDEFIC (unless the beneficiary has OHI). WPS/TDEFIC sends its payment for TRICARE- covered services directly to the provider. Beneficiaries receive Medicare summary notices and TRICARE Explanations of Benefits (EOBs) indicating the amounts paid:

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

See the **claims processing and billing information** section for information about TFL claims and coordinating with OHI. For more information about TFL, call WPS/TDEFIC at **1-866-773-0404** or visit *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. To fill prescriptions, beneficiaries need written prescriptions and valid uniformed services ID cards or Common Access Cards (CACs).

TRICARE beneficiaries have the following options for filling prescriptions:

- **Military hospital or clinic pharmacies:** Using a military pharmacy is the least expensive option, but formularies may vary by military pharmacy location. Contact the local military hospital/clinic pharmacy to check availability before prescribing a medication.
- **TRICARE Pharmacy Home Delivery:** TRICARE Pharmacy Home Delivery is the preferred method when not using a military pharmacy. This method adds convenience and provides cost savings for the beneficiary and the DOD. Prescriptions may be sent to TRICARE Pharmacy Home Delivery through e-prescribe (Express Scripts), Fax (**1-877-895-1900**), called in (**1-877-363-1303, Option 6**), or mailed (Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954). Beneficiaries may also contact Express Scripts (**1-877-363-1303**) and request to have any existing prescriptions transferred to home delivery.
- **TRICARE retail network pharmacies:** Beneficiaries can access a network of approximately 58,000 retail pharmacies in the United States and U.S. territories (American Samoa*, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands).

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

- **Non-network retail pharmacies:** Filling prescriptions at a non-network retail pharmacy is the most expensive option and is not recommended to beneficiaries.
- **E-Prescribe:** TRICARE civilian network as well as non-network providers can send prescriptions electronically to military pharmacies, TRICARE Pharmacy Home Delivery, or to retail network pharmacies. Prescribing electronically provides for more timely fills, less prescribing errors, reduced outreach to providers for clarification, and an enhanced experience for the beneficiary. For information, visit the TRICARE Pharmacy Program website (*express-scripts.com/TRICARE/safety_savings/prescribing.shtml*).

All Category II (C-II) prescriptions filled through TRICARE Pharmacy Home Delivery require the prescriber's handwritten signature and must be mailed to Express Scripts. For more information about benefits and costs, visit ***TRICARE.mil/pharmacy*** or ***express-scripts.com/TRICARE***, or call Express Scripts at **1-877-363-1303**.

Beneficiaries can manage their prescriptions through their TRICARE Pharmacy online account available at ***express-scripts.com/TRICARE*** or by using the Express Scripts mobile app available at ***express-scripts.com/mobileapp*** or at their mobile service provider app store. These resources will allow the patient full visibility and management of their medication regardless of the point of service that they use for dispensing.

Prior authorizations

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

For a general list of TRICARE-covered prescription drugs requiring prior authorization and to access prior authorization and medical necessity criteria forms for retail network pharmacy and Home Delivery prescriptions, visit ***express-scripts.com/static/formularySearch/2.1/#/formularySearch/drugSearch***. Military pharmacies may follow different procedures. At the top of each form, there is information on where to send the completed form. For assistance, call **1-877-363-1303**.

Prescribers may also submit prior authorizations electronically which promotes a more timely response, ensures continuity and allows for an easy reference for future submissions. Proceed to ***covermymeds.com/epa/express-scripts*** login (or establish an account), complete the patient and provider demographics, prescription requirements and the associated Prior Authorization form. When selecting the healthcare plan use TRICARE.

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

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

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

To obtain forms, reference medical necessity criteria, 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 ***express-scripts.com/static/formularySearch/2.1/#/formularySearch/drugSearch*** or Call Express Scripts at **1-877-363-1303**.

Specialty

Beneficiaries utilizing Home Delivery for filling their specialty medications, designated as such by the DoD, are automatically enrolled in The Specialty Medication Care Management Program at no cost. The program complements the care provided by the physician.

TRICARE Extended Care Health Option (ECHO) provider responsibilities

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

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

Providers must obtain prior authorization for all ECHO services, and they may be requested to provide medical records or assist beneficiaries with completing Exceptional Family Member Program (EFMP) documents. Network and participating non-network providers must submit ECHO claims to PGBA, Humana Military's claims processing partner.

TRICARE dental options:

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

Tips for making referrals and authorizations

Submitting a request online at **HumanaMilitary.com** is the quickest and most convenient way to obtain a referral or authorization.

- All network PCM and specialist-to-specialist referral requests will be directed to system-selected providers or to providers the beneficiary has seen in the preceding six months.
- The choice of up to five providers will reflect the optimal options in terms of quality of care, accessibility (e.g., appointment availability), affordability and drive time from the beneficiary's address.

- If the beneficiary resides within a military hospital's catchment area, the services requested may be subject to redirection to the military hospital - known as the Right Of First Refusal (ROFR).
- When completing the referral, always include the sponsor's TRICARE ID, diagnosis and clinical data explaining the reason for the referral.
- If the patient needs services beyond the referral's scope, the PCM must approve additional services.
- Check the status of the referral or authorization at **HumanaMilitary.com** or by phone at **1-800-444-5445**.
- Humana Military will notify the beneficiary and providers of an approved referral or authorization.
- For urgent referrals and authorizations, call **1-800-444-5445**, **press 2** to access the **provider main menu** and **press 3**.

Tips for hospital admission notifications

Submitting the notification online at **HumanaMilitary.com** is the quickest and most convenient way to notify Humana Military of a hospital admission. In many cases, the admission is immediately approved.

Entering a new hospital admission notification is easy. Sign in to **self-service for providers portal**, select **new request for referral or authorization**, including hospital admission and follow the simple steps to complete the request.

Submit continued stay reviews and notify Humana Military of a patient's discharge online. It is important to notify Humana Military when a patient is discharged. This allows the authorization to be completed and the claim to be properly processed.

For mental health care admissions, submit notification online at **HumanaMilitary.com**. This is the quickest and most convenient way to notify ValueOptions Federal Services of a hospital admission. Facilities unable to access the web can fax the TRICARE Higher Level of Care Treatment Report form, available at **HumanaMilitary.com**, to ValueOptions Federal Services at **1-866-811-4422**.

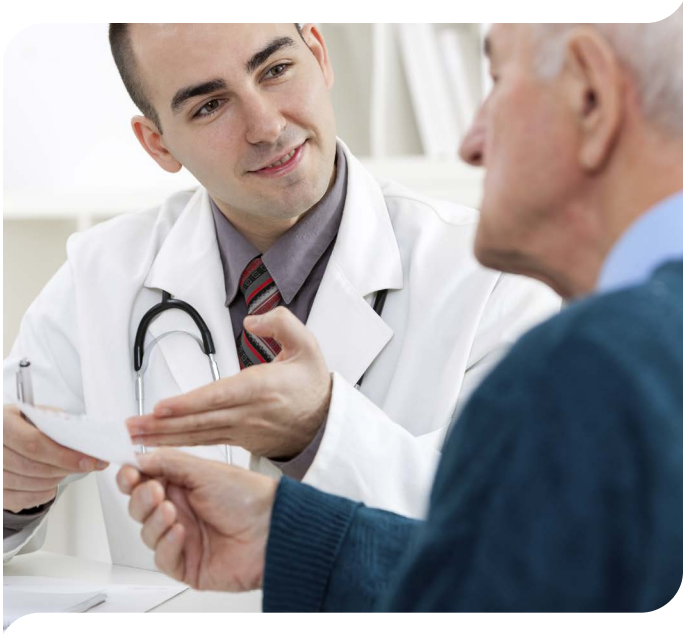
Specialist-to-specialist referrals for the same episode of care

Some referrals may be authorized from one specialty care provider to another, bypassing the need to get another PCM referral. Specialist-to-specialist referrals:

- Apply only when a valid **evaluate and treat referral** from the PCM was previously authorized for the same episode of care
- Do not apply to Active Duty Service Members (ADSMs)
- Are subject to the military hospital or clinic ROFR policy

If you are a specialist referring your patient to another specialist, please keep in mind:

- You, the receiving specialist and the PCM will be notified of all such referrals by automatic fax, keeping the entire care team aware of these clinical contacts
- Not all specialist-to-specialist referrals will be authorized
- If a pediatric patient age five or younger or a patient with a developmental, mental or physical disability requires dental procedures under general anesthesia, the request for prior authorization may be submitted by the dentist



Services requiring prior authorization in the South Region

Procedures and services

- Adjunctive dental care
- Advanced life support air ambulance in conjunction with stem cell transplantation
- Bariatric surgery
- Applied Behavior Analysis (ABA)
- Extended Care Health Option (ECHO) services
  - Home health services, including home infusion
  - Hospice
  - Lab Developed Tests (LDTs)
  - Spinal Fusions and related procedures
  - Transplants (solid organ and stem cell, not corneal transplant

Inpatient hospital stays

- Acute care admissions (Notification of acute care admission is required by the next working day)
- Admissions or transfers to Skilled Nursing Facilities (SNFs), rehabilitation and Long-Term Acute Care (LTAC)
- Discharge notification

Mental health

- Non-emergency admissions to inpatient hospitals for psychiatric and substance use disorders
- Partial Hospitalization Programs (PHPs) for psychiatric and substance use disorders
- Residential Treatment Centers (RTCs)
- Outpatient mental health care visits exceeding the initial eight visits each fiscal year (October 1 to September 30
- Psychoanalysis

Right of First Refusal

Military hospitals and clinics have the Right Of First Refusal (ROFR) to provide care for a TRICARE beneficiary. When a TRICARE Prime beneficiary's civilian network provider is unable to provide a specialized medical service, the network provider must contact Humana Military to request a referral.

Concurrent review

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

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

Retrospective review

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

Discharge planning

Discharge planning begins on admission review and continues throughout the hospital stay. Activities include arranging for services such as home health and DME needed after discharge and coordinating transfers to lower levels of care to minimize inappropriate use of hospital resources.

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

Case management

Humana Military nurses provide case management services for TRICARE beneficiaries with complex health needs. The following conditions warrant mandatory referral to case management:

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

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

Clinical quality management

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

TRICARE Quality Monitoring Contractor

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

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

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

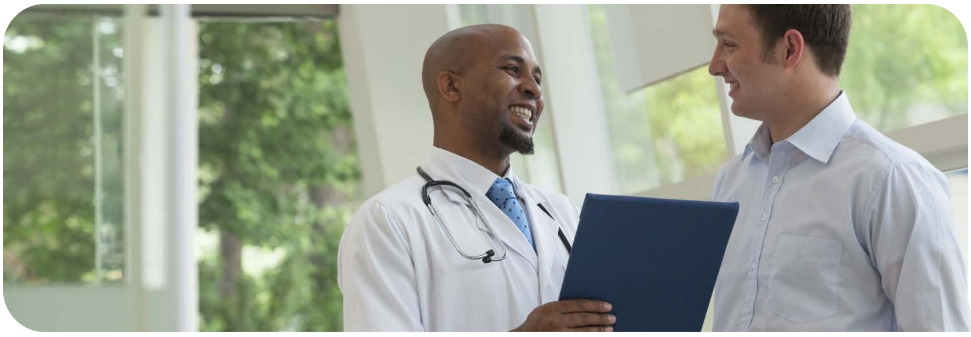
Medical records documentation

Humana Military may review a provider's medical records on a random basis to evaluate patterns of care and compliance with performance standards. Policies and procedures should be in place to help ensure that a beneficiary's medical record is kept organized and confidential. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis and describe the patient's progress and response to medications and services.

Peer review organization agreement

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

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



Appealing a decision

TRICARE beneficiaries have the right to appeal decisions made by DHA or Humana Military. All initial and appeal denials explain how, where and by when to file the next level of appeal.

Where to send appeals for denied referrals or authorizations	
Prior authorization appeals	Humana Military Attn: Utilization Management P.O. Box 740044 Louisville, KY 40201-9973
Mental health care appeals	ValueOptions Federal Services Mental Health Attn: Appeals and Reconsideration Department P.O. Box 551138 Jacksonville, FL 32255-1138

Medical necessity determinations

Medical necessity determinations are based on whether, from a medical point of view, the suggested care is appropriate, reasonable and adequate for the beneficiary's condition. If an expedited appeal is available, the initial and appeal denial decisions will fully explain how to file an expedited appeal.

Factual determinations

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

Proper appealing parties

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

A network provider is never an appropriate appealing party unless the beneficiary has appointed the provider, in writing, to represent him or her for the purpose of the appeal. To avoid a possible conflict of interest, an officer or employee of the U.S. government is not eligible to serve as a representative unless the beneficiary is an immediate family member.

Non-appealable issues notifications

Certain issues are considered non-appealable. Non-appealable issues include the following:

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

Mental health care services

ValueOptions Federal Services is the mental health care contractor for Humana Military for the TRICARE South Region. ValueOptions administers the TRICARE mental health care benefit and manages the mental health care provider network.

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

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

To determine if a specific service is a covered benefit or if coverage is limited, check the current list of non-covered services on the No Government Pay Procedure Code List at ***TRICARE.mil/NoGovernmentPay*** or check the Code Look Up using the secure **self-service for providers portal** at **HumanaMilitary.com**

The information contained in this section is not all-inclusive. See the following pages for a list of mental health care limitations and exclusions.

Mental health care providers

TRICARE covers services delivered by qualified, TRICARE-authorized mental health care providers practicing within the scope of their license to diagnose or treat covered mental health disorders. TRICARE encourages beneficiaries to receive mental health care at military hospitals or clinics, but beneficiaries may be referred to network providers if military hospital or clinic care is not available.

- Psychiatrists and addictionologists
- Psychologists
- Prescriptive privileges for psychologists (PhD): In select states within the United States, licensed clinical psychologists can obtain prescriptive privileges
- Nurse practitioners
- Psychiatric nurses
- Social workers
- Marriage and family therapists
- Pastoral counselors
- Applied Behavior Analysis (ABA; BCBA and BCBA-D)
- TRICARE certified MHCs and other clinicians

The TRICARE mental 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). See the Join the Network section of **HumanaMilitary.com** for networking criteria. (**HumanaMilitary.com /provider/mental-health/join-network**)

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

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

Referral and authorization requirements

TRICARE mental health care referral and authorization requirements vary according to several factors, including, but not limited to, beneficiary status, program option and type of care. Referral and prior authorization requirements for specific services can be found on the following pages. Active Duty Service Members require military hospital or clinic referral for all behavioral health services. Active Duty Service Members require a military hospital or clinic referral for all mental health services.

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

Obtaining referrals and prior authorizations

Providers are required to submit all referrals and requests for authorization through the **self-service for providers portal** at **HumanaMilitary.com**

Initial evaluations

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

Additional evaluations in the same FY require prior authorization from ValueOptions Federal Services, regardless of whether the first eight visits have occurred. Submit requests for prior authorizations for additional evaluations using the secure **self-service for providers portal** at **HumanaMilitary.com**

Telemental health services

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

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

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

Mental health care limitations, authorization requirements, deductibles and cost-shares apply. For more information, visit *TRICARE.mil/CoveredServices/IsItCovered/TelementalHealth.aspx*

Case management

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

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

To refer a patient for a case management evaluation, call ValueOptions Federal Services at **1-800-700-8646** or submit the Case Management Mental Health Referral Form.

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

Discharge planning

Discharge planning begins on admission review and continues throughout the hospital stay. Activities include arranging for outpatient services after discharge or coordinating transfers to lower levels of care to minimize inappropriate use of hospital resources.

To help facilitate beneficiary reintegration following inpatient services and prevent hospital readmissions, ValueOptions Federal Service nurses conduct post-discharge calls to beneficiaries with affective disorders with psychosis and prolonged hospitalization of more than 20 days.

Incident reporting requirements

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

Reportable occurrences as defined by TRICARE include:

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

The point of contact for TRICARE incident reporting is the TQMC.

Limitations and exclusions (Mental health)

For a complete list of Mental Health care services that are generally not covered under TRICARE or are covered with significant limitations, visit ***TRICARE.mil***

Eating disorder programs

An eating disorder program provided within an institutional facility that meets the requirements to be certified as a TRICARE-authorized institutional provider is covered.

Eating disorder services rendered in a freestanding eating disorder program that fails to meet the certification requirements of one of the institutional provider categories are excluded from coverage.

Outpatient services

TRICARE covers medically and psychologically necessary behavioral health care services, for Substance Use Disorders, Mental Disorders and Behavioral Disturbances in Inpatient and Outpatient settings.

Substance use covered services include inpatient detoxification, inpatient rehabilitation, partial hospitalization and outpatient services.

Psychiatric hospital levels of care include inpatient, partial hospitalization and residential treatment center services.

Outpatient services include outpatient psychotherapy, psychological testing and assessment, Applied Behavior Analysis (ABA), electroconvulsive therapy (ECT) and telemental health services.

Covered services information

Outpatient mental health care covered services

Service	Coverage details	Prior authorization	Frequency limitations
Psychiatric diagnostic interview examination	• Initial evaluation counts toward the initial eight outpatient visits each Fiscal Year (FY). Active Duty Service Members (ADSMs) require referrals	• Not required (unless more than one session requested within same FY [October 1 to September 30]	• One per beneficiary, per FY
Outpatient psychotherapy (physician referral and ongoing communication required when seeing licensed or certified mental health and pastoral counselors and similar non-independent providers)	Covered sessions include: • Psychotherapy (individual up to 60 minutes, family or conjoint up to 90 minutes, group up to 90 minutes) • Crisis intervention (individual up to 120 minutes, family or conjoint up to 180 minutes) • Collateral visits	• Required after initial eight visits per beneficiary, per FY. • ADSMs must have a referral or authorization before receiving any care outside of a military hospital or clinic • Required for psychoanalysis	• A provider cannot bill for more than two sessions per calendar week without prior authorization from ValueOptions Federal Services • Multiple sessions of the same type cannot be billed on the same day
Psychological and neuropsychological testing	• Covered when medical necessity exists and performed in conjunction with otherwise-covered psychotherapy	• Required after the first six sessions per FY	• Psychological testing is generally limited to six hours per FY, but ValueOptions Federal Services may approve more hours on a case-by-case basis
Medication management	• Covered when provided as an independent procedure and rendered by a provider who is authorized to prescribe the medication	• Requires prior authorization from ValueOptions Federal Services • ADSMs must have a referral or authorization before receiving any care outside of a military hospital or clinic	• A provider cannot bill for more than two sessions per calendar week without prior authorization from ValueOptions Federal Services
Electroconvulsive therapy	• May be covered when medically necessary and must be rendered by a qualified provider	• Not required	• None

Inpatient mental health care covered services

Service	Coverage details	Prior authorization	Frequency limitations
Acute inpatient psychiatric care	• For stabilization of a life-threatening or severely disabling mental health condition • Psychiatric emergency admissions are required when, based on a psychiatric evaluation, the beneficiary is at immediate risk of serious harm to self or others and requires immediate, continuous, skilled observation	• Required for all mental health admissions • Notify ValueOptions Federal Services within 24 hours of emergency admission and no more than 72 hours after admission	• 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 30 or 45 day limit • ValueOptions Federal Services may approve additional days, as appropriate, based on medical necessity
Residential Treatment Center (RTC) (must be TRICARE-authorized by KePRO, Inc.)	• Covered for children and adolescents (up to age 21) with psychological disorders who require continued treatment in a therapeutic environment	• Required	• Up to 150 days per FY or for a single admission • ValueOptions Federal Services may approve additional days, as appropriate, based on medical necessity

Inpatient mental health care covered services (continued)

Service	Coverage details	Prior authorization	Frequency limitations
Partial Hospitalization Program (PHP) (Freestanding PHPs must be TRICARE-authorized by KePRO, Inc.)	• For stabilization or treatment of partially stabilized mental health disorders • Serves as a transition from an inpatient program when medically necessary • Appropriate for crisis stabilization\ Does not require 24 hour-a-day care in an inpatient setting	• Requires referral and prior authorization from ValueOptions Federal Services	• Up to 60 treatment days (full or half day program) per FY or for any single admission • Does not count toward 30 or 45 day mental health care inpatient limit

Substance use disorder covered services

Service	Coverage details	Prior authorization	Frequency limitations
Inpatient detoxification	• Covered when medically necessary for active medical treatment of acute phases of substance use withdrawal (detoxification) when the patient's condition requires the personnel and facilities of a hospital	• Required for all inpatient detoxification admissions without exception Notify ValueOptions Federal Services within 24 hours of emergency admission and no more than 72 hours after admission	• Up to seven days per episode in a TRICARE-authorized facility • Counts toward 30 or 45 day inpatient behavioral health care limit Does not count toward 21 day rehabilitation limit
Inpatient rehabilitation	• Follows the detoxification period • Care must occur in an inpatient or PHP setting. (See PHP requirements below)	• Required	• Up to 21 days of rehabilitation per year, per benefit period • Up to three benefit treatment episodes per lifetime • Counts toward 30 or 45 day inpatient behavioral health care limit
Outpatient care	• Outpatient care must be provided by an approved Substance Use Disorder Rehabilitation Facility (SUDRF)	• Required	• 60 individual or group therapy visits per benefit period • 15 family therapy visits per benefit period
Partial Hospitalization Program (PHP) (Freestanding PHPs must be TRICARE-authorized by KePRO, Inc.)	• May be used alone or as a step-down from inpatient rehabilitation • Must be a TRICARE-authorized SUDRF (freestanding or hospital based)	• Required	• Up to 21 treatment days (full or half day program) per FY • Counts toward 60 day limit per FY

Noncovered behavioral health care services

- Aversion therapy (including electric shock and the use of chemicals for alcoholism, except for Antabuse® [disulfiram], which is covered for the treatment of alcoholism)
- Behavioral health care services and supplies related solely to obesity and/or weight reduction
- Biofeedback for psychosomatic conditions
- Counseling services not medically necessary in the treatment of a diagnosed medical condition (e.g., educational counseling, vocational counseling, nutritional counseling, stress management, marital therapy or lifestyle modifications)
- Court-ordered treatment that is not otherwise medically necessary is excluded from coverage.
- Custodial nursing care
- Diagnostic admissions
- Educational programs
- Experimental procedures
- Marathon therapy
- Megavitamin or orthomolecular therapy
- Psychosurgery (Surgery for the relief of movement disorders, electroshock treatments and surgery to interrupt the transmission of pain along sensory pathways are not considered psychosurgery)
- Services and supplies not medically or psychologically necessary for the diagnosis and treatment of a covered condition
- Services for V-code or Z-code diagnoses
- Sexual dysfunction therapy
- Surgery performed primarily for psychological reasons (e.g., psychogenic)
- Therapy for developmental disorders, such as dyslexia, developmental mathematics disorders, developmental language disorders and developmental articulation disorders
- Unproven drugs, devices and medical treatments or procedures

Claims information

South Region claims processor

PGBA, LLC

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

Payments made to network and non-network providers for medical services rendered to beneficiaries shall not exceed 100 percent of the TRICARE allowable charge for the services. Visit ***TRICARE.mil/CMAC*** to find the TRICARE allowable charges.

If TRICARE is the secondary payer, submit the claim to the primary payer first. If the claim processor's records indicate that the beneficiary has one or more primary insurance policies, submit EOB information from the other insurers along with the TRICARE claim.

Humana Military will coordinate benefits when a claim has all necessary information (e.g., billed charges, beneficiary's copay and OHI payment). In order for Humana Military to coordinate benefits, the EOB must reflect the patient's liability (copay and/or cost-share), the original billed amount, the allowed amount and/or any discounts. If the EOB indicates that a primary carrier has denied a claim due to failure to follow plan guidelines or use network providers, TRICARE will also deny the claim.

TRICARE does not always pay the beneficiary's copay or the balance remaining after the OHI payment. However, the beneficiary liability is usually eliminated. The beneficiary should not be charged the cost-share when the TRICARE EOB shows no patient responsibility.

Payment calculations differ by provider status as detailed below.

TRICARE provider categories

Cat.	Provider type	Facility type
1	Medical Doctors (MDs), Doctors of Osteopathic Medicine (DOs), optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, audiologists, Certified Nurse Midwives (CNMs) and applicable outpatient hospital services (See chapter 5 of the *TRICARE Reimbursement Manual*.)	Services provided in a facility[1]
2	MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, audiologists, CNMs and applicable outpatient hospital services	Services provided in a nonfacility[2]
3	All provider types not found in Category 1	Facility setting
4	All provider types not found in Category 2	Nonfacility setting

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 copay, 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, then no TRICARE payment is authorized, the charge is considered paid in full and the provider may not bill the beneficiary. If the service is considered noncovered by TRICARE, the beneficiary may be liable for these charges.

With all other providers, TRICARE pays the lesser of:

- 115 percent of the allowed amount minus the OHI payment
- The amount TRICARE would have paid without OHI
- The beneficiary's liability (OHI copay, 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 as a primary payer.
- Point-Of-Service (POS) cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. However, the beneficiary must have prior authorization for certain covered services, regardless of whether he or she has OHI.

Note: Requests must be postmarked or received within 90 calendar days of the date of the TRICARE EOB.

Send all requests to:

TRICARE South Region Customer Service Department
P.O. Box 7032
Camden, SC 29020-7032

Signature on file requirements

Providers must keep a "**signature on file**" for TRICARE-eligible beneficiaries to protect patient privacy, release important information and prevent fraud. A new signature is required for each admission for claims submitted on a UB-04 claim form but only once each year for professional claims submitted on a CMS-1500 claim form.

Claims for diagnostic tests, test interpretations and certain other services do not require the beneficiary's signature. Providers submitting these claims must indicate "patient not present" on the claim form.

1. *A facility includes the following: ambulances, Ambulatory Surgery Centers (ASCs), community mental health centers, hospices, hospitals (both inpatient and outpatient where the hospital generates a revenue bill; i.e., revenue code 510), military hospitals or clinics, psychiatric facilities, Residential Treatment Centers (RTCs) and Skilled Nursing Facilities (SNFs).*
2. *A nonfacility includes the following: home settings, provider offices and other nonfacility settings.*

Mentally or physically disabled TRICARE beneficiaries age 18 or older who are incapable of providing signatures may have a legal guardian appointed or a power of attorney issued on their behalf. This legal documentation must include the guardian's signature, full name, address, relationship to the patient and the reason the patient is unable to sign.

The first claim a provider submits on behalf of the beneficiary must include the legal documentation establishing the guardian's signature authority. Subsequent claims may be stamped with "**signature on file**" in the beneficiary signature box of the CMS-1500 or UB-04 claim form.

If the beneficiary does not have legal representation, the provider must submit a written report with the claim to describe the patient's illness or degree of mental disability and should annotate in box 12 of the CMS-1500 claim form: "patient's or authorized person's signature—unable to sign." If the beneficiary's illness was temporary, the signature waiver must specify the dates the illness began and ended. Providers should consult qualified legal counsel concerning signature requirements in particular circumstances involving mental or physical incapacity.

Certificate of Medical Necessity (CMN)

An appropriate and complete physician order or certificate of medical necessity (CMN) is required to the DME/Supplier for the services, items, or supplies being requested regardless of referral or authorization requirements. The physician order or CMN must be signed and is considered supporting documentation for the DME/Supplier to have on file and submit with their TRICARE claims confirming the order, quantity, and length of time needed. More information is available at **HumanaMilitary.com** under our DME/CMN guidelines.

Claims for beneficiaries using Medicare and TRICARE

Wisconsin Physicians Service/TRICARE Dual Eligible Fiscal Intermediary Contract (WPS/TDEFIC) is the claims processor for all TRICARE for Life (TFL) claims. Providers who currently submit claims to Medicare on a patient's behalf do not need to submit a claim to WPS/TDEFIC. WPS/TDEFIC has signed agreements with each Medicare carrier allowing direct, electronic transfer of TRICARE beneficiary claims to WPS/TDEFIC. Beneficiaries and providers will receive EOBs from WPS/TDEFIC after processing.

Note: Participating providers accept Medicare's payment amount. Non-participating providers do not accept Medicare's payment amount and are permitted to charge up to 115 percent of the Medicare-approved amount. Both participating and non-participating providers may bill Medicare.

When TRICARE is the primary payer, all TRICARE requirements apply. Refer to the *TRICARE Reimbursement Manual*, chapter 13 at ***manuals.TRICARE.osd.mil***

TRICARE and third-party liability insurance

The Federal Medical Care Recovery Act allows the government to be reimbursed for costs associated with treating a TRICARE beneficiary who has been injured in an accident caused by someone else. When a claim appears to have possible third-party involvement, required actions can affect total processing time.

Inpatient claims submitted with diagnosis codes 800 to 999, regardless of the billed amount, and outpatient professional claims that exceed a TRICARE liability of $500, which indicate an accident, injury or illness, will be pended for research. Claims will not be processed further until the beneficiary completes and submits a Statement of Personal Injury—Possible Third Party Liability (DD Form 2527.)

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 DHA. TRICARE beneficiaries who have OHI do not need referrals or prior authorizations for covered services except for those services listed below, which require prior authorization even when OHI coverage exists.

OHI: services requiring TRICARE prior authorization

- Adjunctive dental care
- Mental health care services
- All non-emergency inpatient admissions for substance use disorder or mental health care services
- Partial Hospitalization Programs (PHPs) and residential treatment center (RTC) programs
- Psychoanalysis
- Outpatient behavioral health visits exceeding eight visits in a Fiscal Year (October 1 to September 30)
- Extended Care Health Option (ECHO) services
- Home health services
- Hospice services
- Solid organ and stem-cell transplants

If the OHI benefits are exhausted, TRICARE becomes the primary payer, and additional referral/prior authorization requirements may apply. Since OHI status can change at any time, always ask all beneficiaries about OHI, including National Guard and Reserve members and their families.

If a beneficiary's OHI status changes, update patient billing system records to avoid delays in claim payments. If a provider indicates that there is no OHI, but Humana Military's files indicate otherwise, a signed or verbal notice from the beneficiary will be required to inactivate the OHI record.

In some cases, the TRICARE Summary Payment Voucher/Remit will state, "Payment reduced due to OHI payment," and there may be no payment and no beneficiary liability. The TRICARE cost-share (the amount of cost-share that would have been taken in the absence of primary insurance) is indicated on the TRICARE Summary Payment Voucher/Remit only to document the amount credited to the beneficiary's catastrophic cap.

TRICARE and workers' compensation

TRICARE will not share costs for services for work-related illnesses or injuries covered under workers' compensation programs.

Avoiding collection activities

Both network and non-network providers are encouraged to explore every possible means to resolve claims issues without involving debt-collection agencies. Before sending a beneficiary's claim to a collection agency, providers should do one or more of the following:

- Submit an administrative review request to PGBA
- Request an adjustment on an allowable charge review from PGBA

Please wait at least 45 days after submitting a claim before contacting Humana Military. Beneficiaries are responsible for their out-of-pocket expenses, unless the outstanding amount is the beneficiary's deductible, cost-share or copay amount reflected on the provider remittance advice.

Section 1869/1878 Social Security Act—appeals determination

There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.

Claims adjustments and allowable charge reviews

A provider or a beneficiary can request an allowable charge review if either party disagrees with the reimbursement allowed on a claim. This includes "**by report**" or unlisted procedures where a provider can request a review.

The following issues are considered reviewable:

- Allowable charge complaints
- Charges denied as "**included in a paid service**"
- Keying errors/corrected bills
- Eligibility denials/patient not in DEERS
- Cost-share and deductible inquiries/disputes
- Claims denied because the provider is not a TRICARE-authorized provider
- Claims auditing tool denials (except assistant surgeons)
- OHI denials/issues
- Prescription drug coverage
- TPL denials/issues
- Claims denied or payments reduced due to lack of authorization
- POS when reason for dispute is other than emergency care
- Claims denied due to late filing
- Charges denied as a duplicate charge
- Claims denied as "**requested information was not received**"
- Coding issues
- Claims denied because Nonavailability Statement (NAS) is not in DEERS
- Network provider disputes relating to contractual reimbursement amount.

If requesting an allowable charge review, providers must submit the following information:

- A copy of the claim and the TRICARE EOB or TRICARE Summary
- Payment Voucher/Remit
- Supporting medical records and any necessary new information

Appeals and administrative reviews of claims denials

The following are considered appealable issues:

- Claims denied because the service is not covered under TRICARE or exceeds policy limitations/coverage criteria
- Claims denied as not medically necessary
- Claims for assistant surgeon charges denied by the claims auditing tool
- Claims processed as POS only when the reason for dispute is that the service was for emergency care

Note: Network providers must hold the beneficiary harmless for noncovered care. Under the Hold-Harmless policy, the beneficiary has no financial liability and, therefore, has no appeal rights. However, if the beneficiary has waived his or her hold-harmless rights, the beneficiary may be financially liable and may have further appeal rights. Appeal and administrative review requests must be postmarked or received within 90 calendar days of the date of the denial. For TRICARE purposes, a postmark is a cancellation mark issued by the U.S. Postal Service. If the postmark on the envelope is not legible, the date of receipt is deemed to be the date of the filing.

Please mail requests to:

TRICARE South Region
Appeals Department
P.O. Box 202002
Florence, SC 29502-2002

After a request is submitted, Humana Military will notify the provider in writing or by telephone of the outcome. When filing appeals, keep in mind the following:

- All appeal and administrative review requests must be in writing and signed by the appealing party or the appealing party's representative
- All appeal and administrative review requests must state the issue in dispute
- Be certain to include a copy of the initial denial (EOB/provider remittance advice) and any additional documentation in support of the appeal
- If submitting supporting documentation, the timely filing of the appeal should not be delayed while gathering the documentation
- If intending to obtain supporting documentation that is not readily available, file the appeal and state in the appeal letter the intention to submit additional documentation and the estimated date of submission
- Providers must meet the 90 day filing deadline, or the request for reconsideration will generally not be accepted

In addition, include the following information with an appeal:

- Sponsor's SSN or patient's DBN
- Beneficiary's/patient's name
- Date(s) of service
- Provider's address, telephone/fax numbers and email address, if available
- Statement of the facts of the request

Appeals must be requested by an appropriate appealing party persons or providers who may appeal are limited to:

- TRICARE beneficiaries (including minors)
- Participating non-network TRICARE-authorized providers
- A custodial parent or guardian of a minor beneficiary
- A provider denied approval as a TRICARE-authorized provider
- A provider who has been terminated, excluded or suspended
- A representative appointed by a proper appealing party

Examples of representatives are:

- Parents of a minor (If the patient is a minor, his or her custodial parent is presumed to have been appointed his or her representative in the appeal.)
- An attorney
- A network provider

Administrative reviews must be requested by the network provider.

Claims reconsiderations

Participating providers may have claims reconsidered through medical review for issues including:

- Requests for verification that the edit was appropriately entered for the claim
- Situations in which the provider submits additional documentation substantiating that unusual circumstances existed

If a line on a claim is rejected, first review the medical documentation for any additional diagnosis and, if found, submit it on a corrected claim. If other diagnoses are not found after review, providers may request a reconsideration. For questions regarding this editing function, contact PGBA at **1-800-403-3950**.

Send supporting medical record information to:

TRICARE South Correspondence
P.O. Box 7032
Camden, SC 29020-7032

Providers are not permitted to bill TRICARE beneficiaries for services rejected by claims auditing.

Fraud and abuse

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

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

Some examples of fraud include:

- Billing for services, supplies or equipment not furnished or used by the beneficiary
- Billing for costs of noncovered or nonchargeable services, supplies or equipment disguised as covered items
- Violating the participation agreement, resulting in the beneficiary being billed for amounts that exceed the TRICARE allowable charge or cost
- Duplicate billings (e.g., billing more than once for the same service, billing TRICARE and the beneficiary for the same services, submitting claims to both TRICARE and other third parties without making full disclosure of relevant facts or immediate full refunds in the case of overpayment by TRICARE)
- Misrepresentations of dates, frequency, duration or description of services rendered or misrepresentations of the identity of the recipient of the service or who provided the service
- Reciprocal billing (i.e., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed)
- Practicing with an expired, revoked or restricted license (An expired or revoked license in any state or U.S. territory will result in a loss of authorized-provider status under TRICARE)
- Agreements or arrangements between the provider and the beneficiary that result in billings or claims for unnecessary costs or charges to TRICARE

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

Some examples of abuse include:

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

Providers are cautioned that unbundling, fragmenting or code-gaming to manipulate the Current Procedural Technology (CPT®) codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such practices can be considered fraudulent and abusive.

Fraudulent actions can result in criminal or civil penalties. Fraudulent or abusive activities may result in administrative sanctions, including suspension or termination as a TRICARE-authorized provider.

The DHA Office of General Counsel works in conjunction with the Program Integrity Branch to deal with fraud and abuse. The DoD Office of Inspector General and other agencies investigate TRICARE fraud.

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

Reimbursement methodologies

State-prevailing rates

State-prevailing rates are established for codes that have no current available TRICARE allowable charge pricing. Prevailing rates are those charges that fall within the range of charges most frequently used in a state for a particular procedure or service.

When no fee schedule is available, a prevailing charge is developed for the state in which the service or procedure is provided. In lieu of a specific exception, prevailing profiles are developed on:

- A statewide basis (Localities within states are not used, nor are prevailing profiles developed for any area larger than individual states)
- A nonspecialty basis

See the *TRICARE Reimbursement Manual*, chapter 5, section 13 at ***manuals.TRICARE.osd.mil*** for the latest details about prevailing rates.

Ambulance Fee Schedule (AFS) for TRICARE

The *TRICARE Policy Manual,* chapter 8, section 1.1 and *TRICARE Reimbursement Manual,* chapter 1, section 14 and chapter 5, section 1-3 includes the change to AFS and provides detail on Ground/Air Ambulance services, transfers, and appropriate claim filing information. TRICARE manuals can be found at ***manuals.TRICARE.osd.mil***

Anesthesia claims and reimbursement

Professional anesthesia claims must be submitted using the Current Procedural Terminology (CPT®) anesthesia codes. If applicable, the claim must also be billed with the appropriate physical-status modifier and, if needed, other optional modifiers.

An anesthesia claim must specify who provided the anesthesia. In cases where a portion of the anesthesia service is provided by an anesthesiologist and a non-physician anesthetist performs the remainder, the claim must identify exactly which services were provided by each type of provider. This distinction may be made by the use of modifiers.

Calculating anesthesia reimbursement rates

TRICARE calculates anesthesia reimbursement rates using the number of time units, the Medicare Relative Value Units (RVUs) and the anesthesia conversion factor.

The following formula is used to calculate the TRICARE anesthesia reimbursement:

(Time Units + RVUs)
×
Conversion Factor

Base unit: TRICARE anesthesia reimbursement is determined by calculating a base unit, derived from the Medicare Anesthesia Relative Value Guide, plus an amount for each unit of time the anesthesiologist is in attendance (in the beneficiary's presence).

A base unit includes reimbursement for:

- Preoperative examination of the beneficiary
- Administration of fluids and/or blood products incident to the anesthesia care
- Interpretation of noninvasive monitoring (e.g., electrocardiogram, temperature, blood pressure, oximetry, capnography and mass spectrometry)
- Determination of the required dosage/method of anesthesia
- Induction of anesthesia
- Follow-up care for possible postoperative effects of anesthesia on the beneficiary

Services **not** included in the base unit include: placement of arterial, central venous and pulmonary artery catheters and the use of transesophageal echocardiography. When multiple surgeries are performed, only the RVUs for the primary surgical procedure are considered, while the time units should include the entire surgical session.

Note: This does not apply to continuous epidural analgesia.

Time unit: Time units are measured in 15-minute increments, and any fraction of a unit is considered a whole unit. Anesthesia time starts when the anesthesiologist begins to prepare the beneficiary for anesthesia care in the operating room or in an equivalent area. It ends when the anesthesiologist is no longer in personal attendance and the beneficiary may be safely placed under postanesthesia supervision. Providers must indicate the number of time units in column 24G of the CMS-1500 form.

Conversion factor: The sum of the time units and RVUs is multiplied by a conversion factor. Conversion factors differ between physician and non-physician providers and vary by state, based on local wage indexes.

For more specific information on anesthesia reimbursement calculation and methodologies, refer to the *TRICARE Reimbursement Manual* at ***manuals.TRICARE.osd.mil***

Anesthesia procedure pricing calculator

For an anesthesia rate calculator, go to ***TRICARE.mil/anesthesia*** and follow the online prompts.

Ambulatory surgery grouper rates

Only non-OPPS providers are reimbursed under this methodology. Hospital-based surgery procedures are reimbursed under OPPS.

Ambulatory surgery facility payments fall into one of 11 TRICARE grouper rates. All procedures identified by the DHA for reimbursement under this methodology can be found at ***manuals.TRICARE.osd.mil***. TRICARE payment rates established under this system apply only to the facility charges for ambulatory surgery.

Ambulatory surgery providers may view reimbursements, ambulatory surgery rates and grouper assignments by visiting ***TRICARE.mil/ambulatory***

Ambulatory surgery center charges

All hospitals or freestanding Ambulatory Surgery Centers (ASCs) **must** submit claims for surgery procedures on a UB-04 claim form. Hospital-based ASC providers must use Type of Bill 13X.

Diagnosis-related group reimbursement

DRG reimbursement is a reimbursement system for inpatient charges from facilities. This system assigns payment levels to each DRG based on the average cost of treating all TRICARE beneficiaries in a given DRG. The TRICARE DRG-based payment system is modeled on the Medicare inpatient Prospective Payment System (PPS). A grouper program classifies each case into the appropriate DRG.

The grouper used for the TRICARE DRG-based payment system is the same as the Medicare grouper with some modifications, such as neonate DRGs. For more details, see the *TRICARE Reimbursement Manual* at ***manuals.TRICARE.osd.mil***

TRICARE uses the TRICARE Severity DRG payment system, which is modeled on the Medical Severity DRG payment system.

Online reimbursement rate calculators (TRICARE.mil)

Access these online tools via the websites listed below.

Calculator resource:	**Online access:**
Ambulatory surgery grouper rates	***TRICARE.mil/ambulatory***
Anesthesia procedure pricing	***TRICARE.mil/anesthesia***
TRICARE allowable charges	***TRICARE.mil/CMAC***
Diagnosis-related group rates	***TRICARE.mil/DRGrates***
TRICARE outpatient prospective payment system	***TRICARE.mil/OPPS***

Present-on-admission indicator

Inpatient acute care hospitals paid under the TRICARE DRG-based payment system are required to report a Present-On-Admission (POA) indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. POA is defined as present at the time the order for inpatient admission occurs.

Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered POA. Any hospital-acquired conditions, as identified by Medicare, will not be reimbursed. A list of hospital-acquired conditions can be found at ***TRICARE.mil/DRGrates***

Any claim that does not report a valid POA indicator for each diagnosis on the claim will be denied. The chart below describes the five valid POA codes.

POA code descriptions

POA code	Description
Y	Indicates that the condition was present on admission.
W	Affirms that the provider has determined, based on data and clinical judgment, that it is not possible to document when the onset of the condition occurred.
N	Indicates that the condition was not present on admission.
U	Indicates that the documentation is insufficient to determine whether the condition was present at the time of admission.
1	Prior to Fiscal Year (FY) 2011, signified exemption from POA reporting. The Centers for Medicare & Medicaid Services (CMS) established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-9-CM diagnosis codes is available in the ICD-9-CM Official Coding Guidelines. This exemption to POA reporting is not available for reporting on the electronic 5010. As of FY 2011, signifies unreported/not used. Exempt from POA reporting. (This code is equivalent to a blank on the CMS 1450 UB-04; however, it was determined that blanks are undesirable when submitting this data via 4010A.)

The following hospitals are exempt from POA reporting for TRICARE:

- Critical Access Hospitals (CAHs)
- Long-term care hospitals
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient hospitals
- Inpatient rehabilitation hospitals
- Psychiatric hospitals and psychiatric units
- Sole community hospitals
- U.S. Department of Veterans Affairs (VA) hospitals

Diagnosis-related group calculator

The DRG calculator is available at ***TRICARE.mil/DRGrates***

Providers can locate the Indirect Medical Education (IDME) factor (for teaching hospitals only) and wage index information using the wage indexes and IDME factors file that are also available on the DRG web page. If a hospital is not listed in the wage indexes and IDME factors file, use the zip to wage index file to obtain the wage index for that area by zip code.

Capital and direct medical education cost reimbursement

Facilities may request capital and direct medical education cost reimbursement. Capital items, such as property, structures and equipment, usually cost more than $500 and can depreciate under tax laws. Direct medical education is defined as formally organized or planned programs of study in which providers engage to enhance the quality of care at an institution.

Submit reimbursement requests for capital and direct medical education costs to Humana Military and PGBA, Humana Military's claims processor, on or before the last day of the 12th month following the close of the hospital's cost-reporting period. The request should cover the one-year period corresponding with the hospital's Medicare cost-reporting period. This applies to hospitals (except children's hospitals) subject to the TRICARE DRG-based system.

When submitting initial requests for capital and direct medical education reimbursement, providers should include the following:

- Hospital name
- Hospital address
- Hospital Tax Identification Number
- Hospital Medicare provider number
- Time period covered (must correspond with the hospital's Medicare cost-reporting period)
- Total inpatient days provided to all beneficiaries in units subject to DRG-based payment
- Total TRICARE inpatient days, provided in "allowed" units, subject to DRG-based payment (excluding non-medically necessary inpatient days)
- Total inpatient days provided to Active Duty Service Members (ADSMs) in units subject to DRG-based payment
- Total allowable capital costs (must correspond with the applicable pages from the Medicare cost report)
- Total allowable direct medical education costs (must correspond with the applicable pages from the Medicare cost report)
- Total full-time equivalents for residents and interns
- Total inpatient beds as of the end of the cost-reporting period
- Title of official signing the report
- Reporting date

The submission must include a statement certifying that any changes, if applicable, were made as a result of a review, audit or appeal of the provider's Medicare cost report. Report any changes to Humana Military and PGBA within 30 days of the date the hospital is notified of the change. In addition, the provider's officer or administrator must certify all cost reports.

Bonus payments in health professional shortage areas

Network and non-network physicians — MDs, DOs, podiatrists, oral surgeons and optometrists — who qualify for Medicare bonus payments in Health Professional Shortage Areas (HPSAs) may be eligible for a 10 percent bonus payment for claims submitted to TRICARE. The only mental health care providers who are eligible for HPSA bonuses are MDs and DOs. Non-physicians (PhDs, social workers, counselors, psychiatric nurse practitioners and marriage therapists) are not eligible.

Providers can determine if they are in an HPSA using the U.S. Department of Health and Human Services Health Resources and Services Administration's HPSA search tool at ***hpsafind.hrsa.gov***. The Centers for Medicare and Medicaid Services (CMS) provides HPSA designations along with bonus payment information at ***cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses***

Bonus payments calculations

For providers who are eligible and located in an HPSA, PGBA will calculate a quarterly 10 percent bonus payment from the total paid amount for TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TRICARE Standard/TRICARE Extra, TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) claims and the amount paid by the government on Other Health Insurance (OHI) claims.

Please keep in mind the following:

- The bonus payment is based on the zip code of the location where the service is actually performed, which must be in an HPSA, rather than the zip code of the billing office or other location.
- As of October 1, 2013, the AQ modifier is no longer required except in those instances where zip codes do not fall entirely within a full county HPSA.
- When calculating bonus payment for services containing both a professional and technical component, only the professional component will be used.

For information about bonus payments, refer to the *TRICARE Reimbursement Manual*, chapter 1, section 33 at ***manuals.tricare.osd.mil***

Home health agency pricing

TRICARE pays Medicare-certified Home Health Agencies (HHAs) using a PPS modeled on Medicare's plan. Medicare-certified billing is handled in 60-day care episodes, allowing HHAs to receive two payments of 60 percent and 40 percent, respectively, per 60-day cycle. This two-part payment process is repeated with every new cycle, following the patient's initial 60 days of home health care.

All home health services require prior authorization from Humana Military and must be renewed every 60 days. To receive private duty nursing or additional nursing services/shift nursing, the TRICARE beneficiary may be enrolled in an alternative DHA-approved special program, and a case manager must manage his or her progress.

Skilled Nursing Facility (SNF) pricing

TRICARE pays Skilled Nursing Facilities (SNFs) using the Medicare PPS and consolidated billing. SNF PPS rates cover all routine, ancillary and capital costs of covered SNF services.

SNFs are required to perform resident assessments using the minimum data set. SNF admissions require authorizations when TRICARE is the primary payer. SNF admissions for children under age 10 and CAH swing beds are exempt from SNF PPS and are reimbursed based on DRG or contracted rates. For information about SNF PPS, refer to the *TRICARE Reimbursement Manual*, chapter 8, section 2 at ***manuals.TRICARE.osd.mil***

Sole Community Hospitals (SCH)

A hospital that meets the requirements to be an SCH as determined by the Centers for Medicare and Medicaid Services is considered to be an SCH under TRICARE.

SCHs include hospitals that are: Geographically isolated, serving a population relying on that hospital for most inpatient care, certain small hospitals isolated by local topography or periods of extreme weather.

In general, an SCH is:

- At least 35 miles or more from another "like" hospital; or
- Between 25 and 35 miles from another "like" hospital, and meets other criteria such as bed-size and a certain number of inpatient admissions

The TRICARE program sole community hospital reimbursement policy can be found in *TRICARE Reimbursement Manual*, chapter 14, section 1 located at ***TRICARE.mil***

Durable medical equipment, prosthetics, orthotics and supplies pricing

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) prices are established by using the Medicare fee schedules, reasonable charges or state-prevailing rates. Most Durable Medical Equipment (DME) payments are based on the fee schedule established for each DMEPOS item by state. The services and/or supplies are coded using CMS Healthcare Common Procedure Coding System (HCPCS) Level II codes that begin with the following letters:

- A (medical and surgical supplies)
- B (enteral and parenteral therapy)
- E (DME)
- K (temporary codes)
- L (orthotics and prosthetic procedures)
- V (vision services and hearing aids)

Inclusion or exclusion of a fee schedule amount for an item or service does **not** imply TRICARE coverage or noncoverage.

Use the following modifiers to identify repair/replacement of an item:

- RA (replacement of an item): The RA modifier on claims denotes instances where an item is furnished as a replacement for the same item that has been lost, stolen or irreparably damaged
- RB (replacement of a part of DME furnished as part of a repair): The RB modifier indicates replacement parts of an item furnished as part of the service of repairing the item

DMEPOS pricing information is available at ***TRICARE.mil/DMEPOS***

Luxury/upgraded DME that does not have supporting documentation for medical necessity will be the responsibility of the beneficiary to pay the difference. Please be sure to have a non-covered service waiver form on file in order to bill the beneficiary for the cost above the approved DME item.

Home infusion drug pricing

Home infusion drugs are those drugs (including chemotherapy drugs) that cannot be taken orally and are administered in the home by other means: intramuscularly, subcutaneously, intravenously or infused through a piece of DME. DME verification is not required.

Home infusion drugs are reimbursed according to TRICARE policy. These drugs must be billed using an appropriate HCPCS code along with a specific National Drug Code (NDC) for pricing.

Claims for home infusion will be identified by the place of service and the CMS HCPCS National Level II Medicare codes, along with the specific NDC number, drug units and quantity of the administered drug.

Modifiers

Industry-standard modifiers are often used with procedure codes to clarify the circumstances under which medical services were performed. Modifiers allow the reporting physician to indicate that a service or procedure has been altered by some specific circumstance but has not been changed in definition or code.

Providers may use modifiers to indicate one of the following:

- A service or procedure has both a professional and technical component
- A service or procedure was performed by more than one physician and/or in more than one location
- A service or procedure has been increased or reduced
- Only part of a service, an adjunctive service or a bilateral service was performed
- A service or procedure was provided more than once
- Unusual events occurred during the service
- A procedure was terminated prior to completion

Providers should use applicable modifiers that fit the description of the service, and the claim will be processed accordingly. The CPT and HCPCS publications contain lists of modifiers available for describing services.

Assistant surgeon services

TRICARE policy defines an assistant surgeon as any physician, dentist, podiatrist, certified Physician Assistant (PA), Nurse Practitioner (NP) or CNM acting within the scope of his or her license who actively assists the operating surgeon with a covered surgical service.

TRICARE covers assistant surgeon services when the services are considered medically necessary and meet the following criteria:

- The complexity of the surgical procedure warrants an assistant surgeon rather than a surgical nurse or other operating room personnel
- Interns, residents or other hospital staff are unavailable at the time of the surgery

When billing for assistant surgeon services, please note:

- All assistant surgeon claims are subject to medical review and medical necessity verification.
- Standby assistant surgeon services are not reimbursed when the assistant surgeon does not actively participate in the surgery
- The PA or NP must actively assist the operating surgeon as an assistant surgeon and perform services that are authorized as a TRICARE benefit
- When billing for a procedure or service performed by a PA, the supervising or employing physician must bill the procedure or service as a separately identified line item (e.g., PA office visit) and use the PA's provider number. The supervising or employing physician of a PA must be a TRICARE-authorized provider
- Supervising authorized providers that employ NPs may bill as noted for the PA, or the NP may bill on his or her own behalf and use his or her NP provider number for procedures or services performed

Providers should use the modifier that best describes the assistant surgeon services provided in column 24D on the CMS-1500 claim form:

- Modifier 80 indicates that the assistant surgeon provided services in a facility without a teaching program
- Modifier 81 is used for Minimum Assistant Surgeon when the services are only required for a short period during the procedure
- Modifier 82 is used by the assistant surgeon when a qualified resident surgeon is not available
- Modifier AS is used to designate an assistant at surgery.

Note: Modifiers 80 and 81 are applicable modifiers to use; however, PGBA will most likely wait for medical review to validate the medical necessity for surgical assistance, and medical records may be requested. During this process, the claim also will be reviewed to validate that the facility has (or does not have) residents and interns on staff (e.g., small community hospitals).

Surgeon's services for multiple surgeries

Multiple surgical procedures have specific reimbursement requirements. When multiple surgical procedures are performed, the primary surgical procedure (i.e., the surgical procedure with the highest allowable rate) will be paid at 100 percent of the contracted rate. Any additional covered procedures performed during the same surgical session will be allowed at 50 percent of the contracted rate.

An incidental surgical procedure is one that is performed at the same time as a more complex primary surgical procedure. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure. Payment for the incidental procedure is considered to be included in the payment of the primary procedure.

Certain codes are considered add-ons or modifier 51 exempt. Procedures for non-OPPS professional and facility claims should not apply a reduction as a secondary procedure.

Outpatient Prospective Payment System (OPPS)

TRICARE OPPS is mandatory for both network and non-network providers and applies to all hospitals participating in the Medicare program with some exceptions (e.g., CAHs, cancer hospitals and children's hospitals). TRICARE OPPS also applies to hospital-based Partial Hospitalization Programs (PHPs) subject to TRICARE's prior authorization requirements and hospitals (or distinct parts thereof) that are excluded from the inpatient DRG-based payment system to the extent the hospital (or distinct part thereof) furnishes outpatient services.

Several organizations, as defined by TRICARE policy, are exempt from OPPS:

- CAHs
- Certain hospitals in Maryland that qualify for payment under the state's cost containment waiver
- Hospitals located outside one of the 50 United States, Washington, D.C. and Puerto Rico
- Indian Health Service hospitals that provide outpatient services
- Specialty care providers, including:
  - Cancer and children's hospitals
  - Community mental health centers
  - Comprehensive outpatient rehabilitation facilities
  - VA hospitals
  - Freestanding ASCs
  - Freestanding birthing centers
  - Freestanding end-stage renal disease facilities
  - Freestanding PHPs (psychiatric facilities and Substance Use Disorder Rehabilitation Facilities [SUDRFs])
  - HHAs
  - Hospice programs
  - Other corporate services providers (e.g., freestanding cardiac catheterization and sleep disorder diagnostic centers)
  - SNFs
  - Residential Treatment Centers (RTCs)

TRICARE allowable charge /CMAC fee schedule pricing, including injectable rates on payable claim lines not grouped to an APC, are updated on a quarterly basis. Annual TRICARE allowable charge / CMAC rates generally available and effective February 1 have a two-month lag under OPPS (i.e., April 1 instead of February 1).

For more information on TRICARE OPPS implementation, refer to the *TRICARE Reimbursement Manual*, chapter 13 at ***manuals.TRICARE.osd.mil*** or visit ***TRICARE.mil/OPPS***

Temporary military contingency payment adjustments

Network hospitals that have received OPPS payments of $1.5 million or more for care provided to ADSMs and Active Duty Family Members (ADFMs) during an OPPS year (May 1 through April 30) will be given a Temporary Military Contingency Payment Adjustment (TMCPA). Hospitals that qualified for a TMCPA received a 20 percent increase in the total OPPS payments for the initial year of OPPS (May 1, 2009 through April 30, 2010). Subsequent adjustments have been reduced by 5 percent each year until the OPPS payment levels are reached in year five (i.e., 15 percent in year two, 10 percent in year three and 5 percent in year four).

Filing claims for PHP charges

The TRICARE OPPS pays claims filed for hospital outpatient services, including hospital-based PHPs (psychiatric and SUDRFs) subject to TRICARE's prior authorization requirements. The outpatient code editor logic requires that hospital-based PHPs provide a minimum of three units of service per day in order to receive PHP payment.

TRICARE has adopted Medicare's PHP reimbursement methodology for hospital-based PHPs. There are two separate APC payment rates under this reimbursement methodology:

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

In addition, TRICARE allows physicians, clinical psychologists, clinical nurse specialists, NPs and PAs to bill separately for their professional services delivered in a PHP. The only professional services included in the PHP per diem payment are those furnished by clinical social workers, occupational therapists, and alcohol and addiction counselors.

The claim must include a 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 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 ***manuals.TRICARE.osd.mil***

Hospice pricing

Hospice programs are not eligible for TRICARE reimbursement unless they enter into an agreement with TRICARE. National Medicare hospice rates will be used for reimbursement of each of the following levels of care provided by, or under arrangement with, a Medicare-approved hospice program:

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

The national Medicare payment rates are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice. The only amounts that will be allowed outside of the locally adjusted national payment rates and not considered hospice services will be for direct patient-care services rendered by either an independent attending physician or a physician under contract with the hospice program.

When billing, hospices should keep in mind the following:

- Bill for physician charges/services (physicians under contract with the hospice program) on a UB-04 claim form using the appropriate revenue code of 657 and the appropriate CPT codes
- Payments for hospice-based physician services will be paid at 100 percent of the TRICARE allowable charge and will be subject to the hospice cap amount (calculated into the total hospice payments made during the cap period)
- Bill independent attending physician services or patient-care services rendered by a physician not under contract with or employed by the hospice on a CMS-1500 claim form using the appropriate CPT codes. These services will be subject to standard TRICARE reimbursement and cost-sharing/deductible provisions, and will not be included in the cap amount calculations

Provider tools

Acronyms

ABA	Applied Behavior Analysis
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
CAC	Common Access Card
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CHCBP	Continued Health Care Benefit Program
CMAC	CHAMPUS Maximum Allowable Charge
DCAO	Debt Collection Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DoD	Department of Defense
DTF	Dental Treatment Facility
ECHO	Extended Care Health Option
EFMP	Exceptional Family Member Program
EHHC	ECHO Home Health Care
FY	Fiscal Year
HPSA	Health Professional Shortage Area
IVR	Interactive Voice Response
LOD	Line Of Duty
LDT	Laboratory Developed Test
MCSC	Managed Care Support Contractor
MHS	Military Health System
MMSO	Military Medical Support Office
NAS	Nonavailability Statement
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OPPS	Outpatient Prospective Payment System
PCM	Primary Care Manager
PHP	Partial Hospitalization Program
POS	Point Of Service
PRAF	Patient Referral Authorization Form
RTC	Residential Treatment Center
SUDRF	Substance Use Disorder Rehabilitation Facility
SHCP	Supplemental Health Care Program
SPOC	Service Point Of Contact
TAMP	Transitional Assistance Management Program
TCSRC	Transitional Care for Service-Related Conditions
TDP	TRICARE Dental Program
TFL	TRICARE For Life
TMCPA	Temporary Military Contingency Payment Adjustment
TOP	TRICARE Overseas Program
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRIAP	TRICARE Assistance Program
TRR	TRICARE Retired Reserve
TRS	TRICARE Reserve Select
TSC	TRICARE Service Center
TTPA	Temporary Transitional Payment Adjustment
TYA	TRICARE Young Adult
USFHP	US Family Health Plan
USPHS	U.S. Public Health Service
VA	Department of Veterans Affairs
VAMC	VA Medical Center
WNAP	Warrior Navigation and Assistance Program

Glossary of terms

Accepting assignment

Those instances when a provider agrees to accept the TRICARE allowable charge.

Authorization for care

The determination that the requested treatment is medically necessary, delivered in the appropriate setting, a TRICARE benefit and that the treatment will be cost-shared by the Department of Defense.

Base Realignment and Closure Commission (BRAC) site

A military base that has been closed or targeted for closure by the government BRAC.

Beneficiary

A person who is eligible for TRICARE benefits. Beneficiaries include ADFMs and retired service members and their families. Family members include spouses and unmarried children, adopted children or stepchildren up to the age of 21 (or 23 if full-time students at approved institutions of higher learning and the sponsor provides at least 50 percent of the financial support). Other beneficiary categories are listed in the *TRICARE Eligibility* section.

Beneficiary Counseling and Assistance Coordinators (BCACs)

Persons at military hospitals or clinics and TRICARE Regional Offices who are available to answer questions, help solve health care-related problems and assist beneficiaries in obtaining medical care through TRICARE. BCACs were previously known as Health Benefits Advisors (HBAs). To locate a BCAC, visit ***TRICARE.mil/BCACDCAO***

Catastrophic cap

The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given Fiscal Year (October 1 to September 30). Point-Of-Service (POS) cost-shares and the POS deductible are not applied to the catastrophic cap.

Catchment area

Geographic areas determined by the Assistant Secretary of Defense (Health Affairs) that are defined by a set of five-digit ZIP codes, usually within an approximate 40-mile radius of a military inpatient treatment facility.

Note: Humana Military — and all other contractors responsible for administering TRICARE — is required to offer TRICARE Prime in each catchment area.

CHAMPUS Maximum Allowable Charge (CMAC)

The CHAMPUS (Civilian Health and Medicaid Program of the Uniformed Services) Maximum Allowable Charge is the maximum amount TRICARE will reimburse for nationally established procedure coding (i.e., codes for professional services). CMAC is the TRICARE allowable charge for covered services.

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

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

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

The health care program established to provide purchased health care coverage for ADFMs and retired service members and their family members outside the military's direct care system. DHA was organized as a separate office under the Assistant Secretary of Defense and replaced CHAMPUS in 1994. The purchased care benefits authorized under the CHAMPUS law and regulations are now covered under TRICARE Standard.

Corporate Services Provider (CSP)

A class of TRICARE-authorized providers consisting of institutional-based or freestanding corporations and foundations that render professional ambulatory or in-home care and technical diagnostic procedures.

Credentialing

The process by which providers are allowed to participate in the TRICARE network. This includes a review of the provider's training, educational degrees, licensure, practice history, etc.

Defense Enrollment Eligibility Reporting System (DEERS)

A database of uniformed services members (sponsors), family members and others worldwide who are entitled under law to military benefits, including TRICARE. Beneficiaries are required to keep DEERS updated. Refer to the *TRICARE Eligibility* section for more information.

Designated Provider (DP)

Under the US Family Health Plan (USFHP), DPs (formerly known as uniformed services treatment facilities) are selected civilian medical facilities around the United States assigned to provide care to eligible and enrolled USFHP beneficiaries — including those who are age 65 and older — who live within the DP area. At these DPs, the USFHP provides TRICARE Prime benefits and cost-shares for eligible persons who enroll in USFHP, including those who are Medicare-eligible.

Disease management

A prospective, disease-specific approach to improving health care outcomes by providing education to beneficiaries through non-physician practitioners who specialize in targeted diseases.

Extended Care Health Option (ECHO)

A supplemental program to the TRICARE basic program. It provides eligible and enrolled ADFMs with additional benefits for an integrated set of services and supplies designed to assist in the treatment and/or reduction of the disabling effects of the beneficiary's qualifying condition. Qualifying conditions may include moderate or severe mental retardation, a serious physical disability or an extraordinary physical or psychological condition such that the beneficiary is homebound.

Foreign Identification Number (FIN)

A permanent identification number assigned to a North Atlantic Treaty Organization (NATO) beneficiary by the appropriate national embassy. The number resembles a Social Security Number and most often starts with 6 or 9. TRICARE will not issue an authorization for treatment or services to NATO beneficiaries without a valid FIN.

Laboratory Developed Test (LDT)

A term used to refer to a certain class of in vitro diagnostics (IVDs).

Managed Care Support Contractor (MCSC)

A civilian health care contractor of the Military Health System (MHS) that administers TRICARE in one of the TRICARE regions. Humana Military is an MCSC. An MCSC helps combine the service available at military hospitals or clinics with those offered by the TRICARE network of civilian hospitals and providers to meet the health care needs of the TRICARE beneficiaries.

National Provider Identifier (NPI)

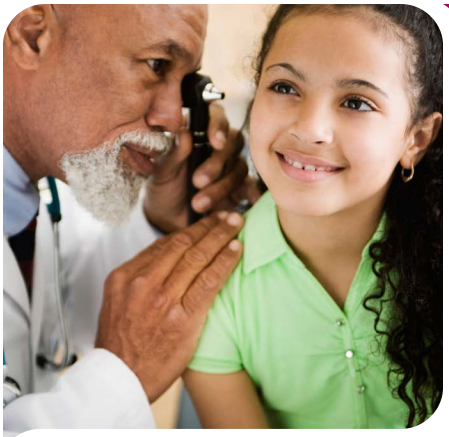
A 10-digit number used to identify providers in standard electronic transactions. It is a requirement of the Health Insurance Portability and Accountability Act of 1996. The National Plan and Provider Enumeration System (NPPES) assigns NPIs to providers.

Nonavailability Statement (NAS)

A certification by a commander (or a designee) of a uniformed services medical hospital or clinic recorded in DEERS, generally for the reason that the needed medical care being requested by a non-TRICARE Prime enrolled beneficiary cannot be provided at the facility concerned because the necessary resources are not available in the time frame needed.

Outpatient Prospective Payment System (OPPS)

TRICARE OPPS is used to pay claims for hospital outpatient services. TRICARE OPPS is based on nationally established Ambulatory Payment Classification amounts and standardized for geographic wage differences that include operating and capital-related costs, which are directly related and integral to performing a procedure or furnishing a service in a hospital outpatient department. TRICARE OPPS became effective May 1, 2009.



Point Of Service (POS)

The option under TRICARE Prime that allows enrollees to self-refer for non-emergency health care services to any TRICARE-authorized civilian provider, in or out of the network. When Prime enrollees choose to use the POS option (i.e., to obtain non-emergency health care services from other than their PCMs or without a referral from their PCMs), all requirements applicable to TRICARE Standard apply except the requirement for a NAS. POS claims are subject to deductibles and cost-shares even after the enrollment/Fiscal Year catastrophic cap has been met. The POS option is not available to ADSMs.

Primary Care Manager (PCM)

A military hospital or clinic provider, team of providers or a network provider to whom a beneficiary is assigned for primary care services at the time of enrollment in TRICARE Prime. Enrolled beneficiaries agree to initially seek all non-emergency, non-mental health care services from their PCMs.

Split enrollment

Split enrollment refers to multiple family members enrolled in TRICARE Prime under different TRICARE regions or MCSCs.

Sponsor

The ADSM, retiree or deceased service member or former service member through whom family members are eligible for TRICARE.

Supplemental Health Care Program (SHCP)

A program for eligible uniformed services members and other designated patients who require medical care that is not available at the military hospital or clinic upon the approval of the cognizant military hospital or clinic commander or the DHA director, as required, to be purchased from civilian providers under TRICARE payment rules.

Transitional Assistance Management Program (TAMP)

A program that provides 180 days of transitional health care benefits to help certain uniformed services members and their families transition to civilian life.

Transitional Care

Designed for all beneficiaries to ensure a coordinated approach takes place across the continuum of care.

TRICARE provider handbook: South Region 2017

Photo by: Master Sgt. Marvin Preston

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