Humana Military | TRICARE®

TRICARE provider news

Up-to-the-minute information for TRICARE® providers in the East Region

ISSUE #3 | 2023

COVID-19 Public Health Emergency (PHE) expiration

The COVID-19 Public Health Emergency (PHE) expired on May 11, 2023, along with TRICARE's temporary coverage and payment for certain services. As a result, key impacts due to the expiration of the PHE include (but are not limited to):

Relaxation of state professional licensing requirements

- The temporary relaxation of state professional licensing requirements has expired.

TRICARE coverage of acute care facilities and temporary expansion of hospital sites, including Medicare's Hospitals Without Walls (HWW) initiative

- Coverage of temporary hospitals, freestanding Ambulatory Surgical Centers (ASC), and other entities enrolled with Medicare as hospitals expires upon the expiration of Medicare's HWW initiative.
- Claims for dates of services through the PHE expiration date will continue to process under the temporary classification.
- Organizations previously considered a TRICARE-authorized, freestanding ASC may return to that classification, provided all federal and state licensure/certification requirements are current.
- If your organization wishes to participate in TRICARE as a hospital and has been certified as such by Centers for Medicare & Medicaid Services (CMS) or The Joint Commission (TJC), please visit HumanaMilitary.com/certify to submit a hospital application.

Certain Critical Access Hospital (CAH) participation requirements

- The requirements that CAHs provide 24-hour emergency care services and no more than 25 beds for acute, hospital-level inpatient care, or swing beds for Skilled Nursing Facility-Level care, and maintain a length-of-stay of no more than 96 hours, determined annually, expire.

You can visit TRICARE Coverage and Payment for Certain Services in Response to the Coronavirus Disease 2019 (COVID-19) Pandemic for complete details on each amendment to TRICARE policy.

Skilled Nursing Facilities (SNF) three-day prior hospital stay requirement waiver

- The waiver for a qualifying hospital stay of three consecutive days or more, not including hospital discharge day, prior to SNF admission, expired on April 10, 2023 with the President's termination of the national emergency.

You can visit Temporary Reimbursement Changes In Response To The Coronavirus Disease 2019 (COVID-19) Pandemic for complete details.

New basic eligibility verification policy

Effective July 24, 2023, providers will no longer be able to obtain basic eligibility details from the call center and must use either self-service or call our automated system at (800) 444-5445.

Basic eligibility details including benefit and coverage types, sponsor information, effective dates, copay and cost-share info, catastrophic cap, deductibles and Other Health Insurance (OHI) information can be found in self-service!

For more information, view the Provider FAQs.

Register for a provider self-service account.

E-prescribe

E-prescribe is simple and secure! Save time by sending prescriptions electronically to your patients' choice of a local military pharmacy, home delivery through Express Scripts or retail pharmacy! Prior authorization may be required from Express Scripts for some medications. Please direct beneficiaries to call Express Scripts at (877) 363-1303 for questions concerning home delivery and member choice support. Find out more about e-prescribe.

Encourage your TRICARE beneficiaries to get regular screenings!

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used tool to measure performances on important dimensions of care and service in the managed care industry. Humana Military works with providers to improve the HEDIS scores of our TRICARE beneficiaries for screenings of breast cancer, cervical cancer, colorectal cancer and diabetes.

Find out more about HEDIS measures and encourage your patients to stay current on their screenings!

Investigational or experimental procedures

- TRICARE only covers medically or psychologically necessary services and supplies.
- Providers cannot bill for investigational or experimental procedures.
- Network and participating non-network providers cannot bill beneficiaries for non-covered services unless the beneficiary agrees in advance, and in writing, to pay for these services.
- X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms are excluded under TRICARE coverage.
- Any treatment that is rendered in conjunction with an experimental procedure is likewise non-covered. If a patient is coming into a practice to receive an investigational treatment, the office visit would also be considered non-covered.
- Some examples:
  - Treatment for COVID-19 using Ivermectin, which is considered an experimental drug for this diagnosis.
  - Medical devices such as Vax-D are unproven.
  - Unproven allergy testing and treatments, such as sublingual testing and sublingual antigen therapy.
- For a more extensive list of TRICARE exclusions, visit the TRICARE website.

Resources:

- TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 1, Section 2.1 - Unproven Drugs, Devices, Medical Treatments, And Procedures
- TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 8, Section 5.1 – Medical Devices
- TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 1, Section 1.2 - Exclusions
- TRICARE Policy Manual 6010-60-M, April 1, 2015, Chapter 7, Section 18.2 - Physical Medicine/Therapy
- TRICARE Policy Manual 6010-60-M, April 1, 2015, Chapter 7, Section 14.1 – Allergy Testing and Treatment
- 32 CRF 199.4 (g) Exclusions and limitations: In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of this part, the following specifically are excluded from the Basic Program:
  - (15) (i) A drug, device, or medical treatment or procedure is unproven.

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Claims go to TRICARE or VA (not both)

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

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

Claims for non-emergency care

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

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

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

Claims for emergency care

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

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

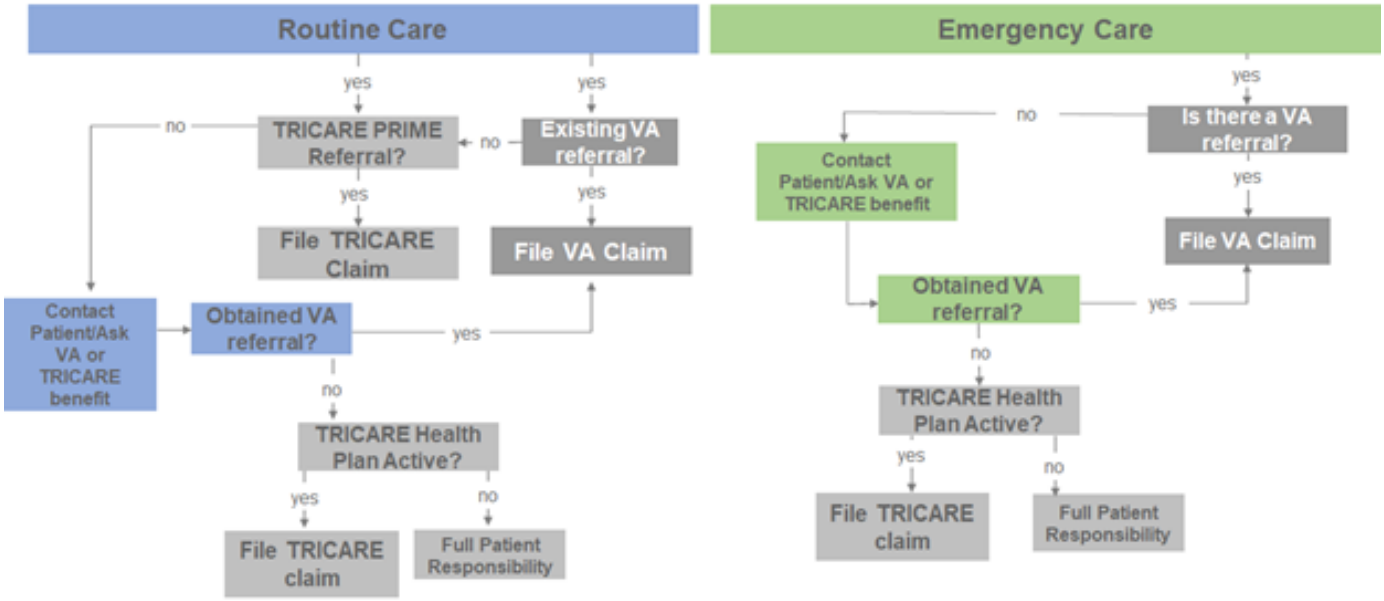

Figure 1. Decision Tree for VA /Tricare Dual-Eligible Veterans

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TRICARE referral and authorization rules

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

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

Visit HumanaMilitary.com for more information about TRICARE authorizations and filing claims with TRICARE.

Provider data management

Provider data accuracy depends on you!

Provider self-service allows you to submit data change requests easily and electronically! Maintaining accurate information ensures not only more timely communications, but it also ensures TRICARE beneficiaries are able to find you in our provider locator tool.

Log in to self service

View Provider data change request for a demonstration of all the updates that can be made through self-service.

Is the drug you're prescribing covered by TRICARE?

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

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

- Advanced medication search options by strength, route, form or type.
- Prior Authorization (PA) and Medical Necessity (MN) forms.
- TRICARE formulary information on products including alternate names, drug options, FAQs.
- Review each pharmacy Point of Service (POS) requirements: Military Pharmacy, home delivery or retail.
  - Check dispensing/fill location options for each product/medication.
  - Find the co-payment of the medication for each POS.
  - Locate quantity limitations, day supply, step therapy or PA/MN clinical requirements.

If your patient needs a medication that requires a PA or MN, such as a non-formulary drug, be sure to submit it to Express Scripts for review before sending to the pharmacy.

- Submit electronically through your desired ePA portal and select TRICARE as the benefit plan
- Download or print the PA or MN form and fax the completed form to: (866) 684-4477
- Call TRICARE: Express Scripts Coverage Review Department: (866) 684-4488

Scan the QR Code to learn more about Express Scripts.

Make sure you're using the latest forms!

To ensure beneficiaries receive and submit accurate and up-to-date information, be sure to save and use the most recent provider forms!

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