TRICARE PROVIDER HANDBOOK: EAST REGION 2018

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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What is TRICARE?

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

TRICARE-eligible beneficiaries may include Active Duty Service Members (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 healthcare professionals and resources to provide high-quality healthcare services. TRICARE is managed in two stateside regions: TRICARE East and TRICARE West.

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

Your regional contractor

A TRICARE contractor since 1995, Humana Military was awarded the next generation TRICARE contract, which combines the former South Region with the North Region to create one new East Region. In partnership with the Department of Defense, Humana Military now provides healthcare services to over six million active duty and retired military and their families in the East Region. The region includes the District of Columbia, and the states of Alabama, Arkansas, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa (Rock Island Arsenal area only), Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri (St. Louis area only); New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas (excluding areas of Western Texas), Vermont, Virginia, West Virginia and Wisconsin.

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

TRICARE Regions:

<table>
<thead>
<tr>
<th>East Region</th>
<th>West Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humana Military</td>
<td>Health Net Federal Services, LLC</td>
</tr>
<tr>
<td>1-800-444-5445</td>
<td>1-844-866-WEST</td>
</tr>
<tr>
<td>HumanaMilitary.com</td>
<td>TRICARE-West.com</td>
</tr>
</tbody>
</table>

Figure 1.1
Humana Military network subcontractor

Wisconsin Physicians Service (WPS) is Humana Military’s claims processing contractor in the TRICARE East Region. The WPS Government Health Administrators division administers Part A and B Medicare benefits for millions of seniors in multiple states and the WPS Military and Veterans Health division serves millions more members who are active in the U.S. military, Veterans and their families.

HumanaMilitary.com

Humana Military’s website hosts a full array of interactive services designed to save providers time and money. Provider self-service features pages customized for providers and Primary Care Managers (PCMs).

Visit HumanaMilitary.com for the following services:

• 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 East Region provider news

Humana Military Interactive Voice Response (IVR)

Providers who do not have internet access can take advantage of Humana Military’s IVR system through our toll-free service line, 1-800-444-5445. The IVR system responds to your natural speech patterns or touch-tone responses and is available 24 hours a day, seven days a week.

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) and TRICARE Manuals. The TRICARE Operations Manual, TRICARE Reimbursement Manual, TRICARE Systems 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 policy changes.

Note: TRICARE-related statutes can be found in Chapter 55 of Title 10 of the United States Code, which contains all statutes regarding the armed forces. Unless specified otherwise, federal laws generally 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 as well as to the TRICARE Provider News publication and HumanaMilitary.com for current information about policy changes, time lines and implementation guidance.

Provider education and locator at HumanaMilitary.com

Provider education at HumanaMilitary.com is available to all providers with internet access. The provider page contains current information and explanations to educate providers in support of the TRICARE program. The list of provider education options and downloadable items includes:

• TRICARE Provider Handbook
• Provider forms
• Provider resources and claims information
• TRICARE provider education PowerPoint® presentations
• Self-guided provider orientation

The locator is the electronic version of a network provider directory. Utilization Review Advisory Committee (URAC) is the accrediting body for our locator. Business rules for display are defined by URAC’s credentialing oversight. TRICARE requires Humana Military to maintain the accuracy of the locator. It is important that all network providers, specialties/services available, location addresses and phone/fax numbers are as current as possible and display within 30 days of any change to that information.

Lack of accurate information can impact the beneficiary’s PCM selection, specialty selection for a referral and adequacy of the network in a geographic area. Please be sure to provide updates and changes as soon as they are known.
Provider self-service

Provider self-service offers many features that will save you time, ensure patient privacy and help manage your office more efficiently. It is simple, secure and available 24 hours a day, seven days a week for registered providers.

With provider self-service, you can quickly and easily:

- Submit claims
- Verify patient eligibility/benefits/claims
- Check claim status
- View remittances
- Create and update referral and authorization requests
- Manage your profile
- Look up codes

Registration is fast and easy. Go to HumanaMilitary.com/ProvSelfService and click on register for self-service in the “get started” heading. Then, follow the prompts to complete your registration.

If you need assistance with registering, logging in, resetting a password, verifying eligibility or another task, check out our guide to provider self-service to learn how to take advantage of this secure tool. Search for self-service guide at HumanaMilitary.com. Enrolling to access provider self-service features requires your 9-digit tax ID or 9 digit EIN with the correlating NPI# as secondary validation.

Gaining access to provider self-service

When registering for provider self-service, providers have four different options for gaining access:

- **Site administrator express code**: Providers may use an express code from a local site administrator responsible for the provider ID they want to access.
- **Existing referral information**: Providers may enter the authorization/order number and key code shown on a received Humana Military—TRICARE Referral/Authorization fax. The provider ID they are requesting access for must be associated with the authorization/order number entered.
- **On-site Humana Military provider representative validation**: The provider representative must enter several key codes to grant a provider immediate access to provider self-service.
- **Manual approval**: If the previous options are unavailable, providers may submit an approval request to a local site administrator (usually a person who works for the provider) for the provider ID they want to access. If a local site administrator does not exist, a Humana Military provider representative will review the request and confirm or deny the right to obtain access.

### Major features include:

<table>
<thead>
<tr>
<th>TRICARE patient profile</th>
<th>Code lookup</th>
</tr>
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<tbody>
<tr>
<td>• Multiple eligibility checks and up to five eligibility checks at a time — in real time!</td>
<td>• Access CPT and diagnosis code lookup about covered procedures and services with messaging that assist in determining referral or authorization needs:</td>
</tr>
<tr>
<td>• Cost-share/copay info</td>
<td>• Limitations and exclusions</td>
</tr>
<tr>
<td>• Program information</td>
<td>• Exempt from Prime referrals</td>
</tr>
<tr>
<td>• Beneficiary eligibility history</td>
<td>• Noncovered service</td>
</tr>
<tr>
<td>• Other Health Insurance (OHI) information</td>
<td></td>
</tr>
<tr>
<td>• Referral by patient status</td>
<td></td>
</tr>
<tr>
<td>• Claims by patient status</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Referrals and authorizations</th>
<th>TRICARE provider profile</th>
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<tbody>
<tr>
<td>• Build referral/authorization request</td>
<td>• Network provider view and update requests by locations</td>
</tr>
<tr>
<td>• Updating existing referrals and authorizations</td>
<td>• Professional provider credentialing status</td>
</tr>
<tr>
<td>• Adding visits and services to referrals</td>
<td>• PCM panel count and listing to include patient detail on referrals, HEDIS alerts and pharmacy</td>
</tr>
<tr>
<td>• Updating admission and discharge dates for inpatient hospital stays</td>
<td>• Network provider types of service by location</td>
</tr>
<tr>
<td>• Extending the coverage period</td>
<td>• Professional provider count and listing by location</td>
</tr>
<tr>
<td>• Adding procedure codes (Most types of service have procedures already identified)</td>
<td></td>
</tr>
<tr>
<td>• Accessing code lookup messages about procedures and diagnoses, shown in red (for example, “no referral required” or “noncovered service”)</td>
<td></td>
</tr>
<tr>
<td>• Selecting a provider</td>
<td></td>
</tr>
<tr>
<td>• Entering up to five lines of pertinent clinical information that will be transmitted to the referred-to provider</td>
<td></td>
</tr>
<tr>
<td>• Many approvals and updates display immediately, saving you time</td>
<td></td>
</tr>
<tr>
<td>• Attach x-rays, pictures and notes where needed</td>
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</tbody>
</table>

### Other provider services

- Provider chat
- Claims status by patient
- User profile and update options
Trusted site information

If you are concerned about misuse of internet access in your office, you can always designate HumanaMilitary.com as a trusted site. A trusted site is a website that you trust not to damage your computer. If the security level of your Internet Explorer browser is high, you may be unable to access a specific website that you trust. To access the website, add the URL to your trusted sites list or change your security level to medium or lower. When using a high security level, you need to add the web application URLs to your trusted sites list.

To add a trusted site in Internet Explorer, follow these steps:

- In the Internet Explorer tools menu, click internet options.
- On the security tab, click trusted sites.
- In the security level for this zone box, you may need to do one of the following:
  - If it is set to high, use the slider to change it to a lower security level.
  - If it is set to custom, click default level and use the slider to change the security level.
  - Note: If you are running Windows Vista, verify that enable-protected mode is not selected.
- Click the sites button.
- In the field, add this website to the zone, type the URL for the trusted website.
- Deselect require server verification for all sites in this zone and click close. In the internet options dialog box, click OK.
  - Note: Mozilla Firefox does not specifically offer a trusted sites setting. However, you can set allowed sites for the limited purpose of installing cookies and add-ons. From the tools menu, select options and go to the security tab.
### Humana Military resources

<table>
<thead>
<tr>
<th>Resource/contact info</th>
<th>Services provided</th>
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<tbody>
<tr>
<td><strong>HumanaMilitary.com</strong></td>
<td><strong>Secure services</strong></td>
</tr>
<tr>
<td>(Access secure features via provider self-service)</td>
<td>• Verify patient eligibility</td>
</tr>
<tr>
<td></td>
<td>• Create referrals and authorizations</td>
</tr>
<tr>
<td></td>
<td>• Review referrals and authorizations</td>
</tr>
<tr>
<td></td>
<td>• Check claim status</td>
</tr>
<tr>
<td></td>
<td>• Manage your profile</td>
</tr>
<tr>
<td></td>
<td>• Access pharmacy data by patient</td>
</tr>
<tr>
<td></td>
<td>• Look up codes</td>
</tr>
<tr>
<td></td>
<td>• Submit claims</td>
</tr>
<tr>
<td></td>
<td>• View remittances</td>
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**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 behavioral health referrals

### Claims resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact information</th>
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</thead>
<tbody>
<tr>
<td><strong>Claims: WPS Health Insurance</strong></td>
<td>TRICARE East Claims</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 7981</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707-7981</td>
</tr>
<tr>
<td></td>
<td>1-800-444-5445</td>
</tr>
<tr>
<td><strong>WPS Electronic Data Interchange (EDI) help desk</strong></td>
<td>1-800-782-2680</td>
</tr>
<tr>
<td></td>
<td>Menu option 1</td>
</tr>
<tr>
<td><strong>WPS provider data management updates</strong></td>
<td>East Region data management</td>
</tr>
<tr>
<td></td>
<td>WPS Health Insurance</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 8923</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707</td>
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### Behavioral health resource

**Behavioral healthcare**

1-800-444-5445

HumanaMilitary.com/provider/health-and-wellness/behavioral-health

### National resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact information</th>
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</thead>
<tbody>
<tr>
<td><strong>TRICARE website</strong></td>
<td>TRICARE.mil</td>
</tr>
<tr>
<td><strong>TRICARE manuals online</strong></td>
<td>manuals.TRICARE.osd.mil</td>
</tr>
<tr>
<td><strong>Defense Health Agency – Great Lakes</strong></td>
<td>Defense Health Agency – Great Lakes</td>
</tr>
<tr>
<td></td>
<td>2834 Green Bay Road, Suite 304</td>
</tr>
<tr>
<td></td>
<td>North Chicago, IL 60064-3091</td>
</tr>
<tr>
<td></td>
<td>1-888-MHS-MMSO (1-888-647-6676)</td>
</tr>
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## TRICARE pharmacy resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact information</th>
</tr>
</thead>
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| 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/2.0/##/formularySearch/drugSearch          |
| Pharmacy prior authorization information and forms            | TRICARE.mil/pharmacy  
Prior Authorization Provider Line: 1-866-684-4488                                                      |
| Medical necessity forms and criteria for non-formulary medications | express-scripts.com/static/formularySearch/2.0/##/formularySearch/drugSearch           |

## Online reimbursement rate calculators (TRICARE.mil)

Access these online tools via the websites listed below. The web posting date indicates when the information was last updated. Rates are updated at least annually or at other intervals at the discretion of TRICARE management activity.

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<tr>
<th>Calculator resource</th>
<th>Online access</th>
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<tr>
<td>Ambulatory surgery grouper rates</td>
<td>TRICARE.mil/Providers/WhatTRICAREPays</td>
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<tr>
<td>Anesthesia procedure pricing</td>
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<tr>
<td>TRICARE allowable charges</td>
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<td>Diagnosis-related group rates</td>
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<td>TRICARE Outpatient Prospective Payment System (OPPS)</td>
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<tr>
<td>TRICARE allowable charges</td>
<td>health.mil/Military-Health-Topics/Business-Support/</td>
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<td></td>
<td>Rates-and-Reimbursement/CMAC-Rates</td>
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</tbody>
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## Other program resources

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<thead>
<tr>
<th>Resource</th>
<th>Contact information</th>
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</table>
| 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)                                                   | TRICARE4U.com  
1-866-773-0404  
1-866-773-0405 (TDD) |
| Wisconsin Physicians Service/TRICARE Dual-Eligible Fiscal Intermediary Contract (WPS/TDEFIC) | Social Security Administration (SSA)  
1-800-772-1213 |
| Warrior Navigation and Assistance Program (WNAP)                        | HumanaMilitary.com/beneficiary/plans-and-programs  
1-888-4GO-WNAP (1-888-446-9627) |
| US Public Health Service (USPHS)                                        | 1-800-279-1605 |

The information contained in these charts is not all-inclusive.
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. For more information, visit HumanaMilitary.com

Healthcare Effectiveness Data and Information Set (HEDIS) performance measures

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 on-going efforts to help TRICARE beneficiaries improve their health and better manage chronic health conditions. This goal also supports the population health segment of the Defense Health Agency’s (DHA) 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 healthcare 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 healthcare operations. The rule also permits uses and disclosures of PHI without a patient’s authorization in various situations not involving treatment, payment and healthcare 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 health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties/Breaches-of-PII-and-PHI

Military Health System (MHS) Notice of Privacy Practices and other information sources

The MHS 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 health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties/HIPAA-Compliance-within-the-MHS/Notice-of-Privacy-Practices 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 health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties/HIPAA-Compliance-within-the-MHS/Notice-of-Privacy-Practices

Beneficiaries and providers may also e-mail inquiries to privacymail@dha.osd.mil For additional questions about the HIPAA Privacy Rule and TRICARE, visit health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties/HIPAA-Compliance-within-the-MHS/Notice-of-Privacy-Practices or hhs.gov/hipaa
What is a TRICARE provider?

TRICARE defines a provider as a person, business or institution that provides healthcare. 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 East Region to deliver healthcare to TRICARE beneficiaries.

TRICARE-authorized providers vs. TRICARE network providers

TRICARE-authorized providers

- TRICARE-authorized providers meet state licensing and certification requirements and are authorized 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 behavioral healthcare providers including Applied Behavior Analysis (ABA) from Board-Certified Behavior Analysts (BCBA) or Board-Certified Behavior Analyst-Doctorate (BCBA-D).
- There are two types of TRICARE-authorized providers: Network and non-network.

Network providers¹

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

TRICARE network providers:

- Have an agreement with Humana Military to provide care.
- Agree to file claims and handle other paperwork for TRICARE beneficiaries.

Non-network providers²

Non-network providers do not have an agreement with Humana Military 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 behavioral health network participation is available from the same web page.)
Military hospitals or clinics (MTF)

A military hospital or clinic is a healthcare facility usually located on a military base. The civilian TRICARE provider network supplements military hospital or clinic resources and may work closely with military hospitals or clinics 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 healthcare management and administration section for more information about referral and authorization requirements.

PCMs can be a part of 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 Healthcare 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/CSP at HumanaMilitary.com. Only after receiving the CSP’s application can Humana Military then network the CSP.

CSPs who deliver home healthcare 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.

TRICARE authorizations and 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 healthcare areas.

Authorized 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. If a non-network provider accepts assignment, he or she is considered a participating non-network provider and agrees to accept the TRICARE allowable charge as payment in full for covered services.

Nonparticipating non-network providers do not have to accept the TRICARE allowable charge or file claims for beneficiaries. All providers must submit certification forms to WPS to become a TRICARE-authorized provider. To download the forms, visit HumanaMilitary.com.

In addition, with the exception of VHA facilities, 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.

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 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 unprobated state license
- Have current acceptable liability insurance
- Be able to participate in federal healthcare 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

Behavioral healthcare providers (including freestanding PHPs, RTCs and SUDRFs), must also be credentialed. For credentialing criteria and to download a PDF application for behavioral healthcare providers, see the behavioral healthcare services section of this handbook, or search join the network at HumanaMilitary.com

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.

TRICARE credentialing

To join the TRICARE network, with the exception of VA providers, a TRICARE-authorized provider must complete the credentialing process and sign a contract with Humana Military.

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 unprobated professional state license* in the state(s) they practice within
- Have a current, valid, unrestricted and unprobated Drug Enforcement Agency (DEA) registration, if applicable to their practicing specialty
- Have a current, valid, unrestricted and unprobated 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 healthcare programs.
- Not have been convicted of a felony related to controlled substances, healthcare fraud, or a child or patient abuse
- Not have any physical or behavioral 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 TRICARE Policy Manual, 6010.60-M April 2015, 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)
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, 6010.59-M April 2015, 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/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 (PCM) role

TRICARE Prime beneficiaries agree to initially seek all non-emergency services from their PCM. PCMs are specified providers selected to provide primary care services at the time of enrollment. 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 healthcare services, as well as any specialty requirements

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

**TRICARE Prime:** ADSMs: PCM and/or Humana Military referrals are required for all civilian specialty care. In addition, prior authorization from Humana Military is required for certain services

**Active Duty Family Members (ADFM):** 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, behavioral healthcare 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 is required for certain services

**TRICARE Select:** Beneficiaries may self-refer to TRICARE-authorized specialty care providers. However, prior authorization from Humana Military is required for certain services

**TRICARE For Life:** Beneficiaries may self-refer to Medicare-certified providers. However, prior authorization from Humana Military is required for certain services

Providers should request referrals and prior authorizations via provider self-service. Humana Military only accepts requests via fax if the provider is not able to submit electronically.

If a civilian specialty provider refers a TRICARE patient to a subspecialist, 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 healthcare 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.

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**Specialty care responsibilities**

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

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 its 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 and the beneficiary may be held harmless.

Network behavioral healthcare providers have agreements to follow rules and procedures regarding behavioral health. Although a PCM referral is not required for these services (except for ADSMs), prior authorization may be required.

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.
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 healthcare providers from billing TRICARE for any professional fees incurred in treating TRICARE-eligible beneficiaries. Civilian medical facilities who employ military or government civilian moonlighting healthcare providers are also prohibited from billing TRICARE for any professional fees incurred by the above providers.

Note: DHA has authorized exceptions on a case-by-case basis for DVA 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 Civilian Health and Medical Program of the Uniformed Services (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.

Centers for Medicare and Medicaid Services (CMS) Meaningful Use

CMS Meaningful Use is a program used for improving patient care by encouraging the use of certified Electronic Health Records (EHR). Using guidelines and criteria established by the government, medical professionals are awarded incentives through three stages of measures. In addition to maintaining privacy and patient security information, EHR technology can enhance the quality, safety and efficiency of healthcare; engagement between patients and family and improve the coordination of all aspects of care.

Department of Veterans Affairs (DVA) healthcare 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 healthcare 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.

DVA and 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.

Health Information Exchange (HIE)

HIE is the electronic sharing of a beneficiary’s vital medical information between patients and their doctors, nurses, pharmacists and other health professionals. HIE is designed to simplify access to and acquisition of clinical data, creating an improved healthcare experience for the beneficiary. HIE enhances the speed, efficiency, security, quality and cost of care, while remaining patient-centric in approach.
**Emergency care**

TRICARE defines an emergency as a serious medical condition the average person would consider to be a threat to life, limb or eyesight that requires immediate medical treatment.

Examples of conditions that require emergency care include:

- Severe bleeding
- Chest pain
- Broken bone
- Loss of consciousness
- Sudden or unexpected weakness or paralysis
- Inability to breathe
- Spinal cord or back injury
- Poisoning
- Suicide attempt
- Drug overdose
- Loss of pulse

Maternity-related medical emergencies are also included that involve a sudden unexpected complication which puts the mother, the baby or both at risk. TRICARE does not consider a delivery after the 34th week an emergency.

To avoid penalties, providers must notify Humana Military of any emergency admission. Provider notification is available 24 hours a day, 7 days a week on HumanaMilitary.com, or 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 nonemergency care without required referrals and/or authorizations, they are responsible for paying Point-Of-Service (POS) fees.

**Urgent care**

Urgent care is defined as care you need for a non-emergency illness or injury that will not become a serious risk to health, but does require professional attention within 24 hours.

Conditions that should receive urgent treatment include earaches, sore throats, high fever or sprains. In many cases, the PCM can provide this care with a same-day appointment.

If a same-day appointment is not available, the PCM may recommend the beneficiary seek care at an urgent care center or convenient care clinic.

**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 providers who accept assignment on the claim agree 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 copays and cost-shares directly from the beneficiaries.

Non-network providers who do not accept assignment or do not “participate” on a claim 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 noncovered service is confirmed prior to the date of service.
Third-party liability

The Federal Medical Recovery Act allows TRICARE to be reimbursed for its costs of treating a TRICARE beneficiary if they are injured in an accident that was caused by someone else.

- WPS will send the beneficiary the Statement of Personal Injury-Possible Third Party Liability (DD Form 2527) if a claim is received that appears to have third-party liability involvement.
- The beneficiary must complete, sign and return the form to WPS within 35 calendar days before the claim can be processed and considered for reimbursement.

Noncovered services

Before delivering care, network providers must notify TRICARE patients if services are not covered. Noncovered services include:

- Services outside of the scope of TRICARE-covered services
- Services that currently have a temporary code or are considered experimental

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

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

The beneficiary must agree in advance and in writing to receive and accept financial responsibility for noncovered services. The agreement must document the specific services, dates, estimated costs and other information. Network providers must use the TRICARE Noncovered Services Waiver form to satisfy these requirements. A general agreement to pay, such as one signed by the beneficiary at the time of admission, is not sufficient to prove that a beneficiary was properly informed or agreed to pay.

If the beneficiary does not sign a TRICARE Noncovered Services Waiver form, the provider is 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.

Hold-harmless policy for network providers

A network provider may not bill a TRICARE beneficiary for excluded or exclucable 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 exclucable and agreed in advance and in writing to pay for the services

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, even when the patient has Other Health Insurance (OHI).

Electronic claims filing

TRICARE providers should make every attempt to submit all claims, encounters and clinical data by electronic means available and accepted as industry standard, which may include claims clearinghouses or EDI companies used by TRICARE/Humana Military.

Providers acknowledge that Humana Military may identify products and services that will expect electronic submission of claims and clinical data in order to be compliant with TRICARE.

An Important Message from TRICARE form

Inpatient facilities are required to provide each TRICARE beneficiary with a copy of the An Important Message from TRICARE form. 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.
Clear and Legible Reports (CLR)

For care referred by a military hospital or clinic, network providers must provide Clear and Legible Reports (CLRs), which include consultation reports, operative reports and discharge summaries to the military hospital or clinic within seven business days of care delivery. Behavioral healthcare network providers must submit brief initial assessments within seven to 10 business days. For Urgent Care Center (UCC) encounters, the CLR shall include the patient’s encounter specifics (histories and physicals, progress notes, notes on Episodes Of Care (EOC), and other patient information (such as laboratory reports, x-ray readings, operative reports), and discharge summaries. In addition, the report will include any referrals made during the urgent care visit. Urgent Care Center CLRs, must be submitted to the military hospital or clinic within two business days of the encounter. Network providers must follow the instructions included on the referral/authorization confirmation from Humana Military.

Beneficiary rights and responsibilities

TRICARE beneficiaries have rights regarding their healthcare and responsibilities for participating in those healthcare decisions.

Beneficiary rights

• Easy-to-understand information about TRICARE
• A choice of healthcare providers that is sufficient to ensure access to appropriate high-quality healthcare
• Emergency healthcare services when and where they are needed
• Review information about the diagnosis, treatment and progress of conditions
• Fully participate in all decisions related to their healthcare or to be represented by family members, conservators or other duly appointed representatives if unable to fully participate in treatment decisions
• Considerate, respectful care from all members of the healthcare system without discrimination based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment
• Communicate with healthcare providers in confidence and have the confidentiality of their healthcare information protected
• Review, copy and request amendments to their medical records
• A fair and efficient process for resolving differences with their health plan, healthcare providers and the institutions that serve them

Beneficiary responsibilities

• Maximize healthy habits, such as exercising, not smoking and maintaining a healthy diet
• Be involved in healthcare decisions, which means working with providers in developing and carrying out agreed-upon treatment plans, disclosing relevant information and communicating their wants and needs
• Be knowledgeable about TRICARE coverage and program options, including covered benefits; limitations; exclusions; rules regarding use of network providers; coverage and referral rules; appropriate processes to secure additional information; and appeals, claims and grievance processes
• Be respectful of other patients and healthcare workers
• Make a good-faith effort to meet financial obligations
• Follow the claims process and use the disputed claims process when there is a disagreement concerning their claims
• Report any wrongdoing or fraud to the appropriate resources or legal authorities.
TRICARE ELIGIBILITY

Verifying eligibility

TRICARE beneficiaries should present their uniformed services ID card at the time of service to verify their eligibility. Those cards include Common Access Cards (CACs), military ID cards or eligibility letters (examples shown below). Be sure to check the expiration date before providing care and make a copy of both sides of the ID card for your patient files.

Note: A CAC or ID card alone does not confirm TRICARE eligibility. All eligibility is based on the Defense Enrollment Eligibility Reporting System (DEERS). Providers can use the sponsor’s Social Security Number (SSN) or DoD benefits number (DBN) to verify either by calling Humana Military’s IVR line at 1-800-444-5445 or visiting HumanaMilitary.com

Common Access Card (CAC)

• Common access cards are used to photo identify active duty personnel, selected reserves, National Guard, National Oceanic and Atmospheric Administration, U.S. Public Health Services and U.S. Coast Guard members and their families.

Military identification cards

• Active Duty Service Members (ADSMs), family members over age 10, retirees and family members will have a military ID card, and like the CAC, will have a photo image of the card bearer.
• DBN/member ID or SSN: Providers may verify the beneficiary’s eligibility using the information supplied on the card. As new military ID cards are issued, a new member ID will replace the sponsor SSN. This new member ID can still be used to verify eligibility. Humana Military’s web-based eligibility check option allows you to use either the sponsor SSN or the new member ID to verify eligibility
• Expiration date: Check the date in the “expiration date” box on the ID card. If expired, the beneficiary must update his or her information in the Defense Enrollment Eligibility Reporting System (DEERS) and be issued a valid card
• Civilian: Check the back of the ID card to verify eligibility for TRICARE civilian care. The center section of the card should read “yes” in the “civilian” box

Note: Beneficiaries who are dual-eligible will have Medicare Part A and Part B and TRICARE. Military ID cards will be similar. An eligibility check will verify TRICARE coverage as secondary.

TRICARE cannot accept or cross-walk a 10-digit number in the Member ID field, which causes claims to reject. Numbers containing dashes also generate an error.

Some possible ID numbers you may encounter:
• SSN: A nine-digit number no longer on ID cards, which is acceptable for claims submissions
• DoD ID number: A 10-digit number on the front of ID cards, which is not acceptable for claims submissions
• DBN: An 11-digit number on the back of some ID cards, which is acceptable for claims submissions (Do not include any dashes)

If the ID card does not include a 9-digit sponsor SSN or an 11-digit DBN, ask the beneficiary to provide the two numbers.

Please review your systems to ensure that your claims submissions contain the appropriately formatted nine-digit SSN or 11-digit DBN. If you have any questions, please call WPS Electronic Data Interchange (EDI) Help Desk at 1-800-782-2680, menu option 1.

Providers may verify TRICARE Prime or TRICARE Select eligibility in one of the following ways:
• At provider self-service, find a patient’s status along with information about the TRICARE copay, cost-share, Other Health Insurance (OHI) and catastrophic cap
• Call Humana Military’s IVR line at 1-800-444-5445. Access the provider main menu, and press # for eligibility and benefits

Providers have the right to collect out-of-pocket costs from beneficiaries prior to seeing the TRICARE patient, or they can file the claim first if it is easier. Both the patient’s Explanation Of Benefits (EOB) and the provider remittance will include copay or cost-share amounts owed.

• Identification cards for family members age 75 and older

All eligible family members and survivors age 75 or older are issued permanent ID cards. These cards should read INDEF (i.e., indefinite) in the expiration date box.
• ADFMs remain eligible for TRICARE Prime and TRICARE Select while the sponsor is on active duty. 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
• Civilian: Check the ID card to verify eligibility for TRICARE civilian care. The Civilian box should read “yes”. A TRICARE For Life (TFL) beneficiary with an ID card that reads “no” in this block may still use TFL if he or she has both Medicare Part A and Medicare Part B coverage
Eligibility for TRICARE and Veterans Affairs (VA) benefits

Veterans eligible for VA healthcare benefits and TRICARE are often referred to as dual-eligible. Eligibility for healthcare through the DVA for a service-connected disability is not considered double coverage. If an individual is eligible for healthcare through both the DVA and TRICARE, he/she may use either TRICARE or Veterans benefits. At any time a beneficiary may get medically necessary care through TRICARE, even if he/she has received some treatment for the same care through the DVA. However, TRICARE will not duplicate payments made by or authorized to be made by the DVA for treatment of a service-connected disability.

Veterans Affairs benefits as Other Health Insurance (OHI)

If beneficiaries are entitled to Department of Veterans Affairs (VA) benefits, they may choose whether to see a TRICARE or VA provider.

If beneficiaries are entitled to Medicare Part A due to age or another reason, they are considered Medicare-eligible and must have Medicare Part B to keep their TRICARE benefit. (Certain beneficiaries may not need Medicare Part B to keep their TRICARE benefit. For more information, visit TRICARE.mil/TFL)

TRICARE beneficiaries with Medicare Part A and Part B are covered by TFL, TRICARE’s Medicare-wraparound coverage. Under TFL, Medicare acts as the primary insurance, and TRICARE acts as the secondary payer. Medicare does not cover VA care, so if beneficiaries seek care from a VA provider while they are using their TRICARE benefit, TFL pays first, and Medicare pays nothing. In this situation, beneficiaries pay the TRICARE Select Calendar Year (CY) deductible, cost-shares and remaining billed charges. Alternatively, they may choose to use their VA benefit when seeing VA providers. To minimize out-of-pocket costs once they are covered by TFL, beneficiaries should seek care from providers who participate in both TRICARE and Medicare.

Verifying benefit coverage

Humana Military encourages providers to use the code lookup feature on provider self-service. By looking up the service or procedure code, you can determine whether the service requires a referral or is exempt from referral requirements if you are seeing a TRICARE Prime member. The code lookup feature also identifies noncovered services and procedures or ones that may be on the No Government Pay Procedure Code List available at health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/No-Government-Pay-Procedure-Code-List

If you do not have access to HumanaMilitary.com, our 1-800-444-5445 IVR line can provide the same coverage information by code or service/procedure description.
TRICARE offers comprehensive medical benefits to all TRICARE-eligible 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 Select. 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 East 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 Select. 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 behavioral healthcare services.

A military hospital or clinic has the 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 (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM)

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 and the Defense Health Agency – Great Lakes (DHA-GL) 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 Prime Point-Of-Service (POS) option

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

The POS cost-share applies when:
- The patient receives medical or behavioral healthcare 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 to a non-network specialty provider for non-emergency behavioral healthcare

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
- Beneficiaries with Other Health Insurance (OHI)
- Outpatient behavioral health visits with network providers for covered conditions that are medically or psychologically necessary

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

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 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 Select

TRICARE Select is available to any TRICARE-eligible beneficiary including active duty military who has not enrolled in TRICARE Prime. Beneficiaries can seek care from any TRICARE-authorized provider with no referral.

TRICARE Select involves cost-shares and deductibles. TRICARE Select patients who see network providers for their care will incur lower out of pocket costs.

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

TRICARE Select 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 behavioral health, adjunctive dental care, home health services) require prior authorization from Humana Military.

See the healthcare management and administration section or the behavioral healthcare 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 healthcare 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,
an advocacy unit specially trained to handle the unique challenges many wounded, ill and injured warriors face in accessing care. The program provides warriors and their families with resources that can help them return to healthy and productive lives.

For more information, visit HumanaMilitary.com or call 1-888-4GO-WNAP (1-888-446-9627).

**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.

**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 Select. 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.

**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 healthcare 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.

**Warrior Navigation and Assistance Program (WNAP)**

Humana Military created the Warrior Navigation and Assistance Program (WNAP) to support ADSMs and National Guard and Reserve members, their families and their providers. The program provides information and assistance to help combat Veterans (ADSMs, National Guard and Reserve members and medically retired service members) navigate military healthcare systems, the Department of Veterans Affairs (VA) health systems, community resources and the civilian healthcare sector.

WNAP offers person-to-person guidance and access to

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**TRICARE PROGRAM OPTIONS**

- 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 obtaining 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 provider self-service or via our 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 DHA-GL. When SHCP beneficiaries need care, the military hospital or clinic (if available) or the DHA-GL 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, copays or deductibles. See the claims processing and billing information section for SHCP claims submission information.

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unless member is on an active federal service)
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 healthcare services.

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 Select. See TRICARE and Medicare eligibility in the TRICARE eligibility section for more information.

How TFL works

Medicare becomes the primary payer, so referrals and prior authorizations from Humana Military are usually not required. However, dual-eligible beneficiaries may need an authorization from Humana Military if Medicare benefits are exhausted or for care covered by TRICARE but not Medicare. See the healthcare 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 Explanation 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 for the National Guard and Reserve**

The seven National Guard and Reserve components include:

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

**TRICARE Reserve Select (TRS)**

TRS is a premium-based health plan that members of the Selected Reserve of the Ready Reserve may qualify to purchase. TRS provides comprehensive healthcare coverage and patient cost-shares and deductibles similar to TRICARE Select, but TRS beneficiaries must pay monthly premiums.

TRS members may self-refer to any TRICARE-authorized provider; however, certain services (e.g., inpatient admissions for substance use disorders and behavioral healthcare, adjunctive dental care, home health services) require prior authorization from Humana Military. See the healthcare management and administration section for more information about referral and authorization requirements.

After purchasing either member-only or member-and-family TRS coverage, TRS members receive TRS enrollment cards. These cards include important contact information but are not required to obtain care. Although beneficiaries should expect to present their cards at the time of service, enrollment cards do not verify TRICARE eligibility. Copy both sides of the cards and retain the copies for files. See the TRICARE eligibility section for information on verifying patient eligibility.

For more information, visit the TRS website at TRICARE.mil/TRS or call 1-877-298-3408, menu option 1.
Whenever possible, military hospitals and clinics provide care to National Guard and Reserve members with LOD conditions. Military hospitals and clinics may refer National Guard and Reserve members to civilian TRICARE providers. If there is no military hospital or clinic nearby to deliver or coordinate care, the DHA-GL may coordinate non-emergency care with any TRICARE-authorized civilian provider.

Humana Military forwards any claim not referred by a military hospital or clinic or pre-approved by the DHA-GL to the DHA-GL for approval or denial. The provider should submit medical claims directly to Humana Military unless otherwise specified in the LOD written authorization or requested by the National Guard or Reserve member’s medical department representative. When submitting claims for a National Guard or Reserve member with an LOD condition, the services listed on the claim must be directly related to the condition documented in the LOD written authorization.

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

### TRICARE Retired Reserve (TRR)

TRR is a premium-based health plan that members of the Retired Reserve may qualify to purchase. TRR provides comprehensive healthcare coverage and patient cost-shares and deductibles similar to TRICARE Select, but TRR beneficiaries must pay monthly premiums.

TRR members may self-refer to any TRICARE-authorized provider; however, certain services (e.g., inpatient admissions for substance use disorders and behavioral healthcare, adjunctive dental care, home health services) require prior authorization from Humana Military. See the healthcare management and administration section for more information about referral and authorization requirements.

After purchasing either member-only or member-and-family TRR coverage, TRR members receive TRR enrollment cards. These cards include important contact information but are not required to obtain care.

Although beneficiaries should expect to present their cards at the time of service, enrollment cards do not verify TRICARE eligibility. Copy both sides of the cards and retain the copies for files. See the TRICARE eligibility section for information on verifying patient eligibility.

For more information, visit the TRR website at [TRICARE.mil/TRR](http://TRICARE.mil/TRR) or call 1-877-298-3408, menu option 1.

### Line-Of-Duty (LOD) care for National Guard and Reserve members

An LOD condition is determined by the military service and includes any injury, illness or disease incurred or aggravated while the National Guard or Reserve member is in a duty status, either inactive duty (such as reserve drill) or active duty status.

This includes the time period when the member is traveling directly to or from the location where he or she performs military duty. The National Guard or Reserve member’s service determines eligibility for LOD care, and the member receives a written authorization that specifies the LOD condition and terms of coverage.

**Note:** The Defense Enrollment Eligibility Reporting System (DEERS) does not show eligibility for LOD care.

LOD coverage is separate from any other TRICARE coverage in effect, such as:

- Transitional healthcare coverage under the Transitional Assistance Management Program (TAMP) or Transitional Care for Service-Related Conditions (TCSRC) program
- Coverage under the TRS program option

### Coverage when activated for more than 30 consecutive days

National Guard and Reserve members with activation orders for more than 30 consecutive days in support of a contingency operation may be TRICARE-eligible for 180 days prior to mobilization and until either deactivation prior to mobilization or until 180 days after deactivation post-mobilization. They are considered ADSMs during the active duty period when on orders. Service members should not enroll in TRICARE Prime or TPR during the early eligibility period, but they must enroll (following command guidance and depending on location) when they reach their final duty stations.

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

TRICARE ECHO provides services to ADFMs who qualify based on specific mental or physical disabilities. It offers beneficiaries an integrated set of services and supplies beyond those offered by the basic TRICARE health benefit programs (e.g., TRICARE Prime, TPRADFM, TRICARE Select). Potential ECHO beneficiaries must be ADFMs, have qualifying conditions and be registered in the Exceptional Family Member Program (EFMP). Each service branch has its own EFMP and enrollment process.

Under certain circumstances, this requirement may be waived. To learn more, contact the beneficiary’s service branch’s EFMP representative or visit TRICARE.mil. A record of ECHO registration is stored with the beneficiary’s DEERS information. Conditions qualifying an ADFM for ECHO coverage may include, but are not limited to:

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

Note: Active duty sponsors with family members seeking ECHO registration must enroll in their service branch’s EFMP — unless waived in specific situations — and register to be eligible for ECHO benefits. There is no retroactive registration for the ECHO program. Visit militaryonesource.mil/efmp/TRICARE for more information about EFMP.

ECHO provider responsibilities

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

Refer patients to 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 EFMP documents. Network and participating non-network providers must submit ECHO claims to WPS, Humana Military’s claims processing partner.

TRICARE Young Adult program (TYA)

The TRICARE Young Adult (TYA) program is a premium-based healthcare plan available for purchase by qualified dependents. Beneficiaries who are adult-age dependents may purchase TYA coverage based on the eligibility established by their uniformed services sponsor and where they live. TYA includes medical and pharmacy benefits, but excludes dental coverage.

Special eligibility conditions may exist. Beneficiaries may purchase TYA coverage if they meet all of the following conditions:

- A dependent of an eligible uniformed services sponsor (If the beneficiary is an adult child of a nonactivated member of the Selected Reserve of the Ready Reserve or of the Retired Reserve, his or her sponsor must be enrolled in TRS or TRR to be eligible to purchase TYA coverage)
- Unmarried
- At least age 21 (or age 23 if enrolled in a full-time course of study at an approved institution of higher learning and if the sponsor provides more than 50 percent of the financial support) but have not yet reached age 26
- Not eligible to enroll in an employer-sponsored health plan as defined in TYA regulations
- Not otherwise eligible for TRICARE program coverage

Note: Active duty sponsors with family members seeking ECHO registration must enroll in their service branch’s EFMP — unless waived in specific situations — and register to be eligible for ECHO benefits. There is no retroactive registration for the ECHO program. Visit militaryonesource.mil/efmp/TRICARE for more information about EFMP.
**ECHO benefits**

ECHO provides coverage for the following products and services:

- Applied Behavioral Analysis (ABA) and other services that are not available through schools or other local community resources
- Assistive services (e.g., those from a qualified interpreter or translator)
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)
- Rehabilitative services
- ECHO respite care (up to 16 hours) during any month when at least one other ECHO benefit is received. (This benefit is limited to the United States, Guam, Puerto Rico and the U.S. Virgin Islands)
- EHHC respite care: Up to eight hours per day, five days per week
- Training to use special education and assistive technology devices
- Institutional care when a residential environment is required
- Transportation under certain limited circumstances (i.e., to and from institutions or facilities to receive otherwise-allowable ECHO benefits)

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

**Note:** All ECHO services require prior authorization from Humana Military. See the healthcare management and administration section for information about ECHO prior authorization requirements in the East Region.

**ECHO costs**

The government’s limit for the cost of ECHO services combined (excluding EHHC) is $36,000 per beneficiary per Fiscal Year (FY). Beneficiaries are responsible for ECHO cost-shares in addition to cost-shares for basic TRICARE benefits (e.g., under TRICARE Prime, TPRADFM, TRICARE Select).

ECHO cost-shares do not count toward the catastrophic cap. EHHC costs do not count toward ECHO yearly maximum cost-shares.

For more information about ECHO, refer to the TRICARE Policy Manual, Chapter 9 at manuals.TRICARE.osd.mil, visit TRICARE.mil/ECHO, visit HumanaMilitary.com or call Humana Military at 1-800-444-5445.

To learn more about ECHO benefits contact a local ECHO case manager:

- **For ECHO medical services:** Case management fax at 800-200-0401
- **For ECHO behavioral health services:** 1-800-444-5445 or by email at: HBH_Military@humana.com

**Comprehensive Autism Care Demonstration (CACD)**

The Comprehensive Autism Care Demonstration (CACD) covers Applied Behavior Analysis (ABA) and related services for eligible beneficiaries diagnosed with Autism Spectrum Disorder (ASD). To be considered eligible, beneficiaries must be either:

- Dependents of active duty, retirees and TRICARE-eligible Reserve components
- Participants in “member plus family coverage” under TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR)
- Individuals covered under the Transitional Assistance Management Program (TAMP) or TRICARE for Life (TFL) Participants in TRICARE Young Adult (TYA)
- North Atlantic Treaty Organization (NATO) dependent beneficiaries
- Individuals no longer TRICARE-eligible who are participating in the Continued Health Care Benefits Program (CHCBP)

Before receiving ABA services, beneficiaries must be diagnosed with ASD based on criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and issued a referral for ABA services by a TRICARE-authorized Physician-Primary Care Manager (P-PCM) or by a specialized ASD-diagnosing provider.

Dependents of ADSMs must also be registered in ECHO to receive ABA under the CACD. For additional information, please visit the Autism Center of Excellence at HumanaMilitary.com.
Transitional healthcare benefits

TRICARE offers three program options for beneficiaries separating from active duty: The Transitional Assistance Management Program (TAMP), the Transitional Care for Service-Related Conditions (TCSRC) program and the Continued Health Care Benefits Program (CHCBP).

Transitional Assistance Management Program (TAMP)

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

Qualifying beneficiaries may enroll in TRICARE Prime if they reside in a PSA, or they can enroll in TRICARE Select. Rules and processes for these programs apply, and beneficiaries are responsible for ADFM costs.

TAMP beneficiaries must present valid uniformed services ID cards or CACs at the time of service. See the TRICARE eligibility section for information about verifying eligibility. For more information, visit TRICARE.mil/TAMP

Note: TAMP does not cover LOD care. See Line-Of-Duty Care for National Guard and Reserve members earlier in this section.

Transitional Care for Service-Related Conditions (TCSRC) program

The TCSRC program extends TRICARE coverage for qualified former ADSMs diagnosed with service-related conditions during their 180-day TAMP period.

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

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

The TCSRC benefit covers care only for the specific service-related conditions. Preventive and health maintenance care is not covered. TCSRC beneficiaries may seek care at military hospitals or clinics or from TRICARE-authorized civilian providers if military hospital or clinic care is not available. There are no copays or cost-shares under TCSRC, and providers must submit claims to Humana Military. The TCSRC benefit is available worldwide. For more information, visit TRICARE.mil/TCSRC

Continued Health Care Benefit Program (CHCBP)

CHCBP is a premium-based healthcare program administered by Humana Military. CHCBP offers temporary transitional healthcare coverage (18 to 36 months) after TRICARE eligibility ends.

CHCBP acts as a bridge between military healthcare benefits and the beneficiary’s new civilian healthcare plan. CHCBP benefits are comparable to TRICARE Select, but differences do exist.

The main difference is that beneficiaries must pay quarterly premiums. In addition, under CHCBP, providers are not required to use or coordinate with military hospitals or clinics.

Providers must coordinate with Humana Military to obtain referrals and authorizations for CHCBP beneficiaries. Providers must seek authorization for care that is deemed medically necessary. Medical necessity rules for CHCBP beneficiaries follow TRICARE Select guidelines.

For more information about CHCBP, including eligibility verification, search for CHCBP at HumanaMilitary.com or call 1-800-444-5445.

To coordinate CHCBP referrals and authorizations, call Humana Military at 1-800-444-5445.

For behavioral health CHCBP referrals and authorizations, contact Humana Military at 1-800-444-5445 or email at HBH_Military@humana.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).

- **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 they use for dispensing.

**Member choice center**

The member choice center helps TRICARE beneficiaries transfer their current retail and military hospital or clinic pharmacy maintenance medication prescriptions to home delivery. If one of a provider’s patients uses the member choice center, an Express Scripts patient-care advocate may contact the provider for patient and prescription information.

To learn more about the member choice center, call Express Scripts at 1-877-363-1303, or visit TRICARE.mil/CoveredServices/Pharmacy/ManageScripts/MedNecessity

**Generic drug use policy**

It is a DoD policy to use generic medications instead of brand name medications whenever possible. A brand-name drug with a generic equivalent may be dispensed only after the prescribing physician completes a clinical assessment that indicates the brand-name drug is medically necessary and after Express Scripts grants approval.

If a patient requires a brand-name medication that has a generic equivalent, the provider must obtain prior authorization. Otherwise, the patient may be responsible for the entire cost of the medication.

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

**Quantity limits**

TRICARE has established quantity limits on certain medications, which means the DoD only pays for up to a specified, limited amount of medication each time the beneficiary fills a prescription. Quantity limits are often applied to ensure medications are safely and appropriately used.

Exceptions to established quantity limits may be made if the prescribing provider is able to justify medical necessity. Visit express-scripts.com/static/formularySearch/2.8/#/formularySearch/drugSearch for a general list of TRICARE-covered prescription drugs that have quantity limits.
Prior authorizations

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

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/2.8/#/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 Express Scripts at 1-877-363-1303.

- **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 alternative is contraindicated
- The patient experiences, or is likely to experience, significant adverse effects from the alternative medicine, and the patient is reasonably expected to tolerate the non-formulary medication
- The 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 acceptable alternative

Call Express Scripts at 1-877-363-1303 or visit for forms and medical necessity criteria. To learn more about medications and common drug interactions, check for generic equivalents or determine if a drug is classified as a non-formulary medication, visit the TRICARE Formulary Search Tool at express-scripts.com/static/formularySearch/2.8/#/formularySearch/drugSearch

Step therapy

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

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

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

TRICARE beneficiaries who were entitled to Medicare Part A prior to April 1, 2001, remain eligible for TRICARE pharmacy benefits without the requirement to have Medicare Part B. Medicare-eligible beneficiaries are able to use the TRICARE Pharmacy Program if they are entitled to Medicare Part A and have Part B.

If they do not have Medicare Part B, they may only access pharmacy benefits at a military hospital or clinic. (Exceptions exist for certain beneficiaries, including ADSMs and ADFMs. Please see TRICARE For Life earlier in this section for more information.)

Medicare-eligible beneficiaries are also eligible for Medicare Part D prescription drug plans. However, beneficiaries do not need to enroll in a Medicare Part D plan to keep their TRICARE Pharmacy Program benefits.

Providers can direct eligible beneficiaries who inquire about Medicare Part D coverage to visit the TRICARE website at TRICARE.mil/MedicarePartD

For the most up-to-date information on the Medicare Part D prescription drug benefit, beneficiaries should call Medicare at 1-800-MEDICARE (1-800-633-4227) or visit medicare.gov

Specialty medication care management

Specialty medications are usually high-cost; self-administered; injectable, oral or infused drugs that treat serious chronic conditions (e.g., multiple sclerosis, rheumatoid arthritis, hepatitis C). These drugs typically require special storage and handling and are not readily available at local pharmacies.

Specialty medications may also have side effects that require pharmacist and/or nurse monitoring. The Specialty Medication Care Management program is structured to improve the beneficiary’s through continuous health evaluation, on-going monitoring and assessment of educational needs and management of medication use. This program provides:

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

These services are provided to beneficiaries at no additional cost when they receive their medications through TRICARE Pharmacy Home Delivery, and participation is voluntary. If a patient orders a specialty medication from TRICARE Pharmacy Home Delivery, Express Scripts sends the patient additional information about the specialty medication care management program and how to get started. Beneficiaries enrolled in the specialty medication care management program have access to pharmacists 24 hours a day, seven days a week. The specialty clinical team contacts the beneficiaries’ physicians, as needed, to address beneficiary issues such as side effects or disease exacerbations. If any patients currently fill specialty medication prescriptions at retail pharmacies, the specialty clinical team will provide brochures detailing the program as well as prepopulated enrollment forms.

If a patient requires specialty pharmacy medications, fax the prescription to TRICARE Pharmacy Home Delivery at 1-877-895-1900. TRICARE Pharmacy Home Delivery ships medications to the beneficiary’s home. Faxed prescriptions must include the following ID information: patient’s full name, date of birth, address and ID number.

Note: Some specialty medications may not be available through TRICARE Pharmacy Home Delivery because the manufacturer limits the drug’s distribution to specific pharmacies. If providers submit a prescription for a limited-distribution medication, TRICARE Pharmacy Home Delivery either forwards the prescription to a pharmacy of the patient’s choice that can fill it or provides the patient with instructions about where to send the prescription. To determine if a specialty medication is available through TRICARE Pharmacy Home Delivery, visit express-scripts.com/static/formularySearch/2.8/###formularySearch/drugSearch
TRICARE Dental Program (TDP)

TDP, administered by United Concordia, is a voluntary dental insurance program available to eligible ADFMs and National Guard and Reserve and Individual Ready Reserve members and their eligible family members.

ADSMs (and National Guard and Reserve members called to active duty for a period of more than 30 consecutive days are eligible for the pre-activation benefit up to 180 days prior to their report date) are not eligible for TDP. They receive dental care at military DTFs or through ADDP.

For more information, visit uccitdp.com or call United Concordia at 1-844-653-4061 (in the continental United States) or 1-844-653-4060 (outside the continental United States).

TRICARE Retiree Dental Program (TRDP)

Delta Dental is the contractor for TRDP. The TRDP is a voluntary dental insurance plan for: retired service members, family members of a retired service member, retired guard/reserve members, family members of retired guard/reserve members, Medal of Honor recipients, family members of Medal of Honor recipient and survivors. To learn more visit: TRICARE.mil/CoveredServices/Dental/TRDP

TRICARE Active Duty Dental Program (ADDP)

United Concordia administers ADDP and provides civilian dental care to ADSMs who are referred for care by a military DTF or who serve on active duty and reside more than 50 miles from a DTF.

Visit ADDP-UCCI.com or TRICARE.mil/dental for more information.

Limitations and exclusions

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

TRICARE dental options

The TRICARE healthcare benefit covers adjunctive dental care (i.e., care that is medically necessary to treat a covered medical condition). However, several non-adjunctive dental care options are available to eligible beneficiaries.

ADSMs receive dental care at military Dental Treatment Facilities (DTFs) or from civilian providers through the TRICARE Active Duty Dental Program (ADDP) if necessary. For all other beneficiaries, TRICARE offers two premium-based dental programs: The TRICARE Dental Program (TDP) or the TRICARE Retiree Dental Program (TRDP). Each program is administered by a separate dental contractor and has its own monthly premiums and cost-shares.

Note: TRICARE may cover some medically necessary services in conjunction with noncovered or non-adjunctive dental treatment for patients with developmental, mental or physical disabilities and for children age 5 years and younger. See the medical coverage section for more details.
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 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 behavioral 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 noncovered 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 noncovered 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 noncovered services on the No Government Pay Procedure Code List at health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/No-Government-Pay-Procedure-Code-List or check the code look up using provider self-service.

The information contained in this section is not all-inclusive. See the behavioral healthcare section for a list of behavioral healthcare limitations and exclusions.

## TRICARE-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

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage details</th>
<th>Prior authorization requirements</th>
</tr>
</thead>
</table>
| **Adjuvante 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, behavioral healthcare issues, need for extensive treatment or need for sedation/anesthesia does not alone qualify a patient for adjuvant dental care coverage.  
• Facility services and supplies may be covered when a patient has a medical condition that might be life threatening during a routine dental procedure. However, TRICARE does not cover the professional dental services or anesthesiology.  
• Facility services, supplies and anesthesiology services may be covered for pediatric patient age five and under and for beneficiaries with severe developmental, mental or physical disabilities undergoing routine dental procedures. Anesthesiology services rendered by a separate anesthesiology provider; however, the professional dental services and anesthesiology services rendered by the attending dentist are not covered. | • Required.  
• Emergency adjuvantive care does not require prior authorization  
• If a pediatric patient age 5 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. |
## Covered outpatient and inpatient services

<table>
<thead>
<tr>
<th>Service</th>
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</tr>
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</table>
| **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.  
  • May be ordered by physicians, dentists or any TRICARE-authorized allied healthcare professional when acting within the scope of their license or certification.  
  • Repairs may be allowed when it is necessary to make the equipment serviceable.  
  • Replacement may be allowed when the DMEPOS is not serviceable due to normal wear, accidental damage or a change in the beneficiary’s condition. Supporting documentation must be submitted with the claim. | • 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.  
  • All orders/prescriptions should be renewed at least annually.                                                                                                                                                                                                                                                                                            |
| **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  
  • Care for accidental injury to the teeth alone or emergency room visits for dental pain are not covered | • 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 on-going care can be coordinated. Requests for authorizations may be entered at [HumanaMilitary.com](http://HumanaMilitary.com) or faxed to 1-877-548-1547                                                                 |
| **Home healthcare**                               | (Provided by participating home healthcare 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  
  • 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                                                                                                                                                                                                 |

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

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**Figure 5.1**
## Covered outpatient and inpatient services

<table>
<thead>
<tr>
<th>Service</th>
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<th>Prior authorization requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice care</strong></td>
<td>Provided in three benefits 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  • Medical care not related to the terminal illness may be covered under the basic TRICARE benefit.</td>
<td>• Required for all hospice care  • If patient does not meet criteria for admission for hospice services, the provider cannot bill TRICARE</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td>• Covered services include: Semiprivate room; 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  • Special care units may be covered if medically necessary</td>
<td>• Notify Humana Military of inpatient admission at HumanaMilitary.com or by faxing 1-877-548-1547 within 24 hours or the next business day</td>
</tr>
<tr>
<td><strong>Maternity care</strong></td>
<td>• Covers medical services related to prenatal care, labor and delivery, and postpartum care  • An approved referral for global OB care begins with the first prenatal visit and remains valid until 42 days after birth and includes the hospital admission for a routine delivery  • Medically necessary ultrasounds. Ultrasounds to determine the sex of the baby are not covered.</td>
<td>• TRICARE Prime PCM for a beneficiary who becomes pregnant must submit a referral request prior to the mother’s first pregnancy-related appointment for global OB care.  • Active Duty beneficiaries require an approved referral for global OB care prior to the first pregnancy related appointment for global OB care. Hospitals are required to notify Humana Military of all admissions for active duty including the routine delivery.  • TRICARE Select or Non-prime beneficiaries do not require a global OB referral or authorization for an admission for a routine delivery.  • TRICARE allows a hospital length of stay of up to 48 hours following a normal vaginal delivery or 96 hours following a cesarean section.  • Notify Humana Military if the mother is hospitalized for a preterm admission 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.</td>
</tr>
</tbody>
</table>
Covered outpatient and inpatient services

<table>
<thead>
<tr>
<th>Service</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility (SNF) care</td>
<td>• 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</td>
<td>• All admissions or transfers to an SNF require prior authorization</td>
</tr>
<tr>
<td></td>
<td>• TRICARE only covers care at Medicare-certified facilities</td>
<td>• TRICARE only covers care at Medicare-certified facilities</td>
</tr>
</tbody>
</table>

Covered clinical preventive services

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedures and frequency limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer screenings</td>
<td><strong>Colonoscopy:</strong></td>
</tr>
<tr>
<td></td>
<td>• For average risk for colon cancer, screenings are covered once every 10 years beginning at age 50.</td>
</tr>
<tr>
<td></td>
<td>• For increased risk, screenings are covered every two years beginning at age 25 or five years younger than the earliest age of diagnosis of colorectal cancer, whichever is earlier.</td>
</tr>
<tr>
<td></td>
<td>• Familial risk of sporadic colorectal cancer (i.e., first-degree relatives with sporadic colorectal cancer or adenomas before age 60 or multiple first-degree relatives with colorectal cancer or adenomas), screenings are covered every three to five years beginning at an age 10 years earlier than the youngest affected relative.</td>
</tr>
<tr>
<td></td>
<td>• Screenings are covered annually after age 40 for individuals with hereditary nonpolyposis colorectal cancer syndrome.</td>
</tr>
<tr>
<td></td>
<td><strong>Computed Tomographic Colonography (CTC):</strong> Covered as a colorectal cancer screening only when an optical colonoscopy is medically contraindicated OR cannot be completed due to a known colonic lesion, structural abnormality or other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is not covered as a colorectal cancer screening for any other indication or reason.</td>
</tr>
<tr>
<td></td>
<td><strong>Fecal Occult Blood Testing (FOBT):</strong> 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.</td>
</tr>
<tr>
<td></td>
<td><strong>Fecal Immunochemical Testing (FIT-DNA):</strong> FDA approved stool DNA tests (e.g., Cologuard™) are covered once every three years beginning at age 50.</td>
</tr>
<tr>
<td></td>
<td><strong>Lung cancer screening:</strong> Low-dose computed tomography are covered annually for persons 55 through 80 years of age with a 30 pack per year history of smoking who are currently smoking or have quit within the past 15 years.</td>
</tr>
<tr>
<td></td>
<td><strong>Mammograms:</strong> Are covered annually beginning at age 40 or at age 30 for women at high-risk (i.e., family history of breast cancer in a first-degree relative). A clinical breast examination should be done for women under age 40 during a covered periodic preventive health exam and annually for women age 40 and older.</td>
</tr>
<tr>
<td></td>
<td><strong>Magnetic Resonance Imaging (MRI) breast screenings:</strong> Are covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20% or greater lifetime risk of breast cancer or who have any of the following risk factors:</td>
</tr>
<tr>
<td></td>
<td>• A known BRCA1 or BRCA2 gene mutation</td>
</tr>
<tr>
<td></td>
<td>• A first-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation who have not had genetic testing themselves</td>
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<tr>
<td></td>
<td>• History of radiation to the chest between the ages of 10 and 30</td>
</tr>
<tr>
<td></td>
<td>• History of Li-fraumeni, cowden or hereditary diffuse gastric cancer syndrome or a first-degree relative with a history of one of these syndromes</td>
</tr>
</tbody>
</table>

The information contained in these charts is not all-inclusive.
### Covered clinical preventive services

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedures and frequency limitations</th>
</tr>
</thead>
</table>
| **Cancer screenings**       | **BRCA1 or BRCA2 genetic counseling and testing:** Genetic counseling rendered by a TRICARE-authorized provider that precedes BRCA1 or BRCA2 gene testing is covered for women who are identified as high-risk for breast cancer by their primary care clinician. BRCA1 or BRCA2 gene testing is covered for women who meet the coverage guidelines outlined in the *TRICARE Operations Manual, Chapter 18, Section 3, Figure 18.3-1*.  
**Oral cavity and pharyngeal cancer:** A complete oral cavity examination should be part of routine preventive care for adults at high-risk due to exposure to tobacco or excessive amounts of alcohol. Oral examination should also be part of a recommended annual dental check-up.  
**Proctosigmoidoscopy or sigmoidoscopy** is covered:  
- For average risk, once every three to five years beginning at age 50.  
- For increased risk (individuals with a family history), once every five years, beginning at age 40.  
- For high-risk (individuals with known or suspected familial adenomatous polyposis), annual flexible sigmoidoscopy, beginning at age 10.  
**Prostate cancer:** One prostate cancer screening is covered every 12 months as part of a clinical preventive exam. Screening includes prostate-specific antigen screening for:  
- Men age 40 and older with a family history of prostate cancer in two or more other family members.  
- Men age 45 and older with a family history of prostate cancer in at least one other family member.  
- All African-American men age 45 and older regardless of family history.  
- All men age 50 and older.  
**Digital rectal examination:** Should be offered annually for all men aged 50 years and over; men aged 45 and over with a family history of prostate cancer in at least one other family member; all African-American men aged 45 and over regardless of family history; and men aged 40 and over with a family history of prostate cancer in two or more other family members.  
**Routine pap smears:** Are covered annually beginning at age 21. Women under age 21 should not be screened regardless of the age of sexual initiation or other risk factors. The frequency of screening pap smears may be at the discretion of the patient and clinician; however, screening pap smears should not be performed less frequently than once every three years.  
**Human Papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing:** HPV DNA testing is covered as a cervical cancer screening only when performed in conjunction with a pap smear, and only for women aged 30 and older.  
**Skin cancer:** Regular skin examinations when a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight or clinical evidence of precursor lesions.  
**Testicular cancer:** Clinical testicular exam annually for males age 13 through 39 with a history of cryptorchidism, orchiopexy or testicular atrophy.  
**Thyroid cancer:** Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.  
| **Cardiovascular**          | **Blood pressure screenings:** Children aged 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:** Age-specific periodic lipid panels as recommended by the National Heart, Lung, and Blood Institute (NHLBI). Refer to NHLBI's website for current recommendations: www.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.  
|
### Covered clinical preventive services

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedures and frequency limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing</strong></td>
<td>All newborns should undergo hearing screening using evoked Otoacoustic Emissions (OAE) testing or automated Auditory Brainstem Response (ABR) testing before one month of age; preferably, before leaving the hospital. An infant who does not pass the hearing screening should undergo appropriate audiological and medical evaluations to confirm the presence of a hearing loss at no later than three months of age. A hearing evaluation should be a part of routine examinations for all children, and those with possible hearing impairment should be referred for appropriate testing.</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>Age-appropriate immunizations and vaccines are covered when following the Centers For Disease Control and Prevention (CDC) age and frequency recommendations. Refer to the CDC’s website for the current schedule of CDC-recommended vaccines: <a href="https://www.cdc.gov">CDC.gov</a></td>
</tr>
</tbody>
</table>
| **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:** One-time screening for females ages 12 to 18, unless there is 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 for HBV in individuals at high-risk for infection.  
**Hepatitis C Virus (HCV) screening:** Screen for HCV in individuals at high-risk for infection and as a one-time screening for adults born between 1945 and 1965.  
**Human Immunodeficiency Virus (HIV) infection screening:** Screen for HIV in individuals ages 15-65. Younger adolescents and older adults who are at increased risk should also be screened.  
**Syphilis infection screening:** Screen at risk individuals for syphilis infection.  
**Chlamydia and gonorrhea screening:** Screen sexually active women age 24 years and younger and older women who are at increased risk for infection.  
**Intensive behavioral counseling for Sexually Transmitted Infections (STIs):** Intensive behavioral counseling (counseling that lasts more than 30 minutes) for all sexually active individuals who are at increased risk for STIs is covered when rendered by a TRICARE-authorized provider. |
| **Physicals**         | • When required for school enrollment.  
• For overseas travel for active duty family members when:  
  • The family member is accompanying an active duty service member on assignment and  
  • Travel is because of orders from a uniformed service.  
• TRICARE doesn’t cover annual sports physicals. |
| **Vision coverage**   | Screening is covered at birth and at six months of age for visual acuity, ocular alignment and red reflex, along with external examination of ocular abnormalities.  
**Routine eye examination:**  
• As needed for active duty service members to maintain fitness for duty  
• Once a year for active duty family members (Prime and Select)  
• Every two years for all other TRICARE Prime beneficiaries (e.g. retired service members, their families, etc.)  
• Once a year for diabetic patients in TRICARE Prime  
**Well-child eye exams:**  
• Every two years beginning at age three  
• Between the ages of three and six, the exam should include screening for lazy eye and crossed eyes  
• You can visit an optometrist or ophthalmologist |

The information contained in these charts is not all-inclusive.
## Covered clinical preventive services

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision coverage</strong></td>
<td>Vision screening is excluded from coverage under the Select plan except for the one routine eye examination per calendar year per person for family members of active duty members.</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td><strong>Body measurement</strong>: For children and adolescents: Height and weight typically is measured and Body Mass Index (BMI)-for-age calculated and plotted at each primary care visit. Head circumference typically is measured through age 24 months. For adults: Height and weight typically is measured and BMI calculated at each primary care visit. <strong>Comprehensive health promotion &amp; disease prevention examinations</strong>: For ages 24 months or older: One comprehensive disease prevention clinical evaluation and follow up during age intervals: 2-4; 5-11; 12-17; 18-39; 40-64. <strong>Diabetes mellitus (type II)</strong>: Screen adults with a sustained blood pressure (treated or untreated) greater than 135/80 mmHg. Screen adults aged 40-70 who are overweight or obese. <strong>Patient &amp; parent education counseling</strong>: Expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge. These services include: • Accident and injury prevention • Cancer surveillance • Depression, stress, bereavement and suicide risk assessment • Dietary assessment and nutrition • Intimate partner violence and abuse • Physical activity and exercise • Promoting dental health • Risk reduction for skin cancer • Safe sexual practices • Tobacco, alcohol and substance abuse <strong>Pediatric blood lead</strong>: Assessment of risk for lead exposure during each well-child visit from age six months through six years is covered. TRICARE covers screenings by blood lead level determination for all children at high-risk for lead exposure per CDC guidelines. <strong>Prenatal screening tests</strong>: This includes but isn’t limited to the following: • Anemia screening • Asymptomatic bacteriuria, urinary tract infection or other infection screening (urine culture at 12-16 weeks gestation) • Gestational diabetes mellitus screening between 24-28 weeks and for those at high-risk of gestational diabetes • Hepatitis B screening • HIV screening • Other screenings as recommended by the U.S. Department of Health and Human Services • RH incompatibility screening • Syphilis screening</td>
</tr>
</tbody>
</table>

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 90 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, TPR or TRICARE Select within 90 days, coverage outside of the Direct Care system is forfeited.

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.
- A maternity emergency-defined as a sudden unexpected medical complication which puts the mother, or fetus, at risk.

Referral and authorization requirements

TRICARE Prime:

- The TRICARE Prime PCM for a beneficiary who becomes pregnant must submit a referral request prior to the mother’s first pregnancy-related appointment for global OB care.
- The approved referral for global OB care begins with the first prenatal visit and remains valid until 42 days after birth and includes the hospital admission for a routine delivery.
- Hospitals are required to notify Humana Military of preterm admissions.

Active Duty:

- Require an approved referral for global OB care prior to the first pregnancy related appointment for global OB care.
- Hospitals are required to notify Humana Military of all admissions for active duty including the routine delivery.

TRICARE Select or Non-Prime admissions:

- Do not require a global OB referral or authorization for an admission for a routine delivery.

TRICARE Prime, Active duty and TRICARE Reserve Select:

- TRICARE allows a hospital length of stay of up to 48 hours following a normal vaginal delivery or 96 hours following a cesarean section.
- Notify Humana Military if the mother is hospitalized for a preterm admission 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.
**Durable Medical Equipment (DME)**

DME refers to durable medical equipment and / or supplies that are necessary for the treatment, habilitation, or rehabilitation of a beneficiary. The equipment should provide the medically appropriate level of performance and quality for the medical condition present.

**Note:** Some Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS) are a limited benefit.

Certificate of Medical Necessity (CMN) is a document signed by the prescribing provider containing clinical information that supports the need for each item/service/supply requested for a beneficiary.

A physician order or prescription itself can take the place of the CMN as long as it includes the necessary elements and signature. It is very important that the CMN or physician order be complete and current for the services/supplies/equipment to be covered. A copy of the CMN or order must be submitted with the claim. Be sure to keep the CMN on file for at least one year.

At a minimum, the CMN must include:

- Type of equipment
- Diagnosis or reason
- Length of need*
- Beginning date
- Physician signature (nurse practitioner and physician assistant signatures are accepted)

*Length of need: A length of need should not exceed a 12-month period. For prescriptions/orders that exceed 12 months, the beneficiary should return to his or her PCM annually for assessment of his or her condition and ongoing treatment/needs and obtain a new prescription/CMN. Length of need can be more than 12 months in the case of lifetime use. (An example of lifetime use would be oxygen. In most cases, if you have a prescription for oxygen you are going to have it for life.)

If there is no length of need on the CMN, the claim will be rejected for missing information.

Any time there is a change in the prescription, the physician must provide an updated or new prescription or CMN for the DME to be submitted for claims.

**Upgraded DME (deluxe, luxury and immaterial features)**

TRICARE will only cover deluxe, luxury and immaterial features for ADSMs.

All other TRICARE beneficiaries who choose to upgrade from a covered DME item to a deluxe, luxury, or immaterial feature for comfort or convenience will need to be responsible for the added cost. (Reference *TRICARE Policy Manual, Chapter 8, Section 2.1* at manuals.TRICARE.osd.mil)

DME providers must obtain a TRICARE specific noncovered service waiver form signed by the beneficiary in advance in order to collect from the beneficiary without fear of holding the beneficiary harmless for the additional cost due to upgrading. You can find a copy of the noncovered services waiver form on HumanaMilitary.com

**Referral/authorization guidelines for DME**

All TRICARE Prime, TRICARE Prime Remote and TRICARE Young Adult Prime beneficiaries require a referral for any DME billed under code E1399 or for any other miscellaneous code. Billed charge is the charge amount or negotiated amount submitted on the claim. E1399 should only be used for special and/or customized equipment for which no other HCPCS code has been assigned.

- Active duty service members require an authorization for all DMEPOS items
- Predetermination is available for non-prime beneficiaries

To determine if a specific DMEPOS is covered, or if a referral or authorization is required, go to the code look up feature on provider self-service.

An approved authorization does not take the place of a certificate of medical necessity (CMN) or physician’s order.

A completed and current CMN or physician’s order is required to submit with the claim.

Referrals and authorizations are generally considered valid for one year. The beneficiary should return to his or her PCM annually for assessment of his or her condition and ongoing treatment/needs and obtain a new referral, if needed.

**DMEPOS rental vs. purchase**

Depending on which is the least expensive for TRICARE, DMEPOS may be leased or purchased. When receiving claims for extended rentals, TRICARE evaluates the cost benefit of purchasing the equipment and will pay only up to the allowable purchase amount. (Reference *TRICARE Reimbursement Manual, Chapter 1, Section 11 Claims for Durable Equipment (DE) and DMEPOS* at manuals.TRICARE.osd.mil)
Repairs: Benefits are allowed for repair of beneficiary-owned DME when it is necessary to make the equipment serviceable. This includes the use of a temporary replacement item provided during the period of repair.

Replacements: Benefits are allowed for replacement of beneficiary-owned DME when the DME is not serviceable due to normal wear, accidental damage, a change in the beneficiary’s condition, or the device has been declared adulterated by the FDA. Exceptions exist for prosthetic devices.

Modifications: A wheelchair, or an approved alternative, which is necessary to provide basic mobility, including reasonable additional cost to accommodate a particular disability, is covered.

A duplicate item of DME which otherwise meets the DME benefit requirement that is essential to provide a fail-safe in-home life-support system is covered.

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 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

Home healthcare

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 demonstrate 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 healthcare benefit.

Respite care for ADSMs who are homebound because 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., DHA-GL or the referring military hospital or clinic).

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

For information about home healthcare, refer to the TRICARE Reimbursement Manual, Chapter 12.

For information about home healthcare 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 17, Section 3, 2.4.3.

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 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, x-ray and Laboratory Developed Test (LDT) 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 charts below.)

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

<table>
<thead>
<tr>
<th>LDT</th>
<th>Specific codes</th>
<th>Covered for the following</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALK</td>
<td>88271 88291</td>
<td>• To determine response to Tyrosine Kinase Inhibitor (TKI) therapy inpatients with adenocarcinoma of the lung or mixed lung cancer with adenocarcinoma component of the lung.</td>
</tr>
</tbody>
</table>
| ATXN1     | 81401          | • Diagnosis of Spinocerebellar Ataxia Type 1 (SCA1) inpatients 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. |
| ATXN2     | 81401          | • Diagnosis of Spinocerebellar Ataxia Type 2 (SCA2) inpatients 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) inpatients 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) inpatients 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 81170 | • Diagnostic assessment of beneficiaries with suspected Chronic Myelogenous Leukemia (CML) by quantitative RT-PCR (RQ-PCR).  
• Diagnostic assessment of beneficiaries with suspected CML by qualitative RT-PCR.  
• Monitoring response to TKI therapy, such as imatinib, in benes with CML by RQ-PCR.  
• Testing for the presence of the BCR/ABL1 p.Thr315Ile variant in CML beneficiaries 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 benes to guide treatment selection following resistance to first-line imatinib therapy. |
| BMPR1A    | 81479          | • To clarify the diagnosis of beneficiaries 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. |

Codes listed are taken from TRICARE Operations Manual, Chapter 18; Sections 13 & 17. Figure 5.2 Please be aware codes are only as current as the date of this document.
**TRICARE guidelines for Laboratory Developed Test (LDT)**

<table>
<thead>
<tr>
<th>LDT</th>
<th>Specific codes</th>
<th>Covered for the following</th>
</tr>
</thead>
</table>
| **BRAF** | 81210 81406 | - To predict response to vemurafenib therapy in patients with a positive cobas 4800 BRAF mutation test result.  
- To predict response to trametinib monotherapy in advanced melanoma patients with a positive BRAF p.Val600Glu and/or p.Val600Lys test result.  
- To predict response to dabrafenib monotherapy in advanced melanoma patients with a positive BRAF p.Val600Glu test result.  
- To predict response to trametinib and dabrafenib combination therapy in advanced melanoma patients with a positive BRAF p.Val600Glu and/or p.Val600Lys test result.  
- For individuals with indeterminate thyroid Fine-Needle Aspiration (FNA) biopsy cytology for diagnosis of papillary thyroid carcinoma. |
| **BRCA Analysis** | 81211 81212 81213 (not covered as a stand-alone test) 81214 81215 81216 81217 81162 | - Beneficiary from families transmitting a known BRCA1/2 variant.  
- Beneficiary 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).  
  - Beneficiary with a personal history of epithelial ovarian cancer.  
  - Beneficiary with male breast cancer.  
  - Beneficiary 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 bene (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 beneficiaries 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.

Codes listed are taken from TRICARE Operations Manual, Chapter 18; Sections 13 & 17. Please be aware codes are only as current as the date of this document.
### TRICARE guidelines for Laboratory Developed Test (LDT)

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</thead>
<tbody>
<tr>
<td>CACNA1A</td>
<td>81401</td>
<td>• Diagnosis of Spinocerebellar Ataxia Type 6 (SCA6) inpatients with cerebellar ataxia</td>
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<tr>
<td></td>
<td></td>
<td>with dysarthria and/or nystagmus.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of SCA6 in symptomatic family members of known SCA6 patients.</td>
</tr>
<tr>
<td>CALM1, CASQ2, RYR2 &amp; TRDN</td>
<td>81405, 81408, 81479</td>
<td>• To confirm a diagnosis of Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) inpatients with clinically diagnosed or suspected CPVT.</td>
</tr>
<tr>
<td>CDH1</td>
<td>81406</td>
<td>• For large rearrangements in the CDH1 gene for the treatment of Hereditary Diffuse Gastric Cancer (HDGC).</td>
</tr>
<tr>
<td>CEBPA</td>
<td>81218</td>
<td>• To guide the treatment decisions for beneficiaries with Acute Myeloid Leukemia (AML).</td>
</tr>
<tr>
<td>Chromosome 22q11.2</td>
<td>88271, 88291</td>
<td>• Confirmation of diagnosis in an individual suspected of chromosome 22q11.2 deletion syndrome based on clinical findings.</td>
</tr>
<tr>
<td>CF testing (Cystic Fibrosis)</td>
<td>81220, 81221, 81222, 81223, 81224</td>
<td>• As part of a newborn screening panel included in well-child care (TRICARE Policy Manual, Chapter 7, Sec 2.5) – handled under the authorization for the delivery. It does not require a separate authorization.</td>
</tr>
<tr>
<td>CFTR (Cystic Fibrosis)</td>
<td>81220, 81221, 81222, 81223, 81224</td>
<td>• Confirmation of diagnosis in beneficiaries showing clinical symptoms of Cystic Fibrosis (CF) or having a high sweat chloride level.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identification of newborns who are affected with CF.</td>
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<td>• Identification of beneficiaries with the p.Gly551Asp variant who will respond to</td>
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<td>treatment with ivacaftor.</td>
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<tr>
<td></td>
<td></td>
<td>• Male infertility testing and treatment.</td>
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<tr>
<td></td>
<td></td>
<td>• Preconception and prenatal carrier screening in accordance with the most current ACOG guidelines.</td>
</tr>
<tr>
<td>Chimerism analysis</td>
<td>81265, 81266, 81267, 81268</td>
<td>• For the management and treatment of stem cell transplant patients.</td>
</tr>
<tr>
<td>COL1A1/COL1A2</td>
<td>81408</td>
<td>• For sequence variants in the COL1A1/COL1A2 genes for the diagnosis of Osteogenesis Imperfecta (OI) when clinical and radiological examination and family history provide inadequate information for diagnosis of OI.</td>
</tr>
</tbody>
</table>

Codes listed are taken from TRICARE Operations Manual, Chapter 18; Sections 13 & 17.

Please be aware codes are only as current as the date of this document.
### TRICARE guidelines for Laboratory Developed Test (LDT)

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<tbody>
<tr>
<td>COL3A1</td>
<td>81479</td>
<td>To confirm or establish a diagnosis of Ehlers-Danlos Syndrome Type 4 (EDS IV), also known as vascular EDS, inpatients with clinical symptoms or features of EDS IV.</td>
</tr>
<tr>
<td>CYP2C9</td>
<td>81227</td>
<td>For the initiation and management of warfarin treatment.</td>
</tr>
<tr>
<td>CYP2C19</td>
<td>81225</td>
<td>To manage dosing of clopidogrel.</td>
</tr>
</tbody>
</table>
| Colaris® for Lynch Syndrome | 81288 81292 81293 81294 81295 81296 81297 81298 81299 81300 81301 81317 81318 81319 81403 | A symptomatic or asymptomatic beneficiary 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 beneficiary 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 beneficiary 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 beneficiary who is less than 60 years of age.  
• Colorectal cancer diagnosed in a beneficiary 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 beneficiary with two or more first or second-degree relatives with Lynch syndrome-associated cancers, regardless of age.  
3. Beneficiary has a known Lynch syndrome mutation in the family.  
4. Endometrial cancer diagnosed in a beneficiary 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 beneficiaries > 18 years of age who are at risk of having a known familial sequence variant in a Mismatch Repair (MMR) gene.  

Codes listed are taken from TRICARE Operations Manual, Chapter 18; Sections 13 & 17. Please be aware codes are only as current as the date of this document.
### TRICARE guidelines for Laboratory Developed Test (LDT)

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</table>
| 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 Preimplantation 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 beneficiaries with clinical symptoms consistent with FAP.  
  - For genetic testing for APC variants in beneficiaries with clinical symptoms consistent with AFAP.  
  - For genetic testing for APC variants in beneficiaries with clinical symptoms consistent with Turcot’s or Gardner’s syndromes.  
  - For testing beneficiaries 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 beneficiaries with colorectal polyposis of unknown etiology and in the siblings and offspring of known MYH-Associated Polyposis (MAP) bene:  
  - For the diagnosis of MAP in APC-negative polyposis beneficiaries or in polyposis beneficiaries who have a family history consistent with autosomal recessive inheritance.  
  - For the diagnosis of MAP in asymptomatic siblings of bene with known MYH variants.  
  - For the testing of offspring or asymptomatic siblings of known MAP beneficiaries in order to provide an accurate recurrence risk to offspring. |
| Cytogenomic Constitutional Microarray Analysis (CCMA)                | 81228, 81229, 81406 |  
  - Diagnostic evaluation of beneficiaries suspected of having a genetic syndrome (i.e., have congenital anomalies, dysmorphic features, Developmental Delay (DD) and/or intellectual disability).  
  - Diagnostic evaluation of beneficiaries with Autism Spectrum Disorder (ASD), including autism, Asperger’s 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, 81161   |  
  - 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. |
| DSC2, DSG2, DSP, JUP, PKP2, RYR2, TGFβ3 & TMEM43                    | 81406, 81408   |  
  - For sequence variants in the DSC2, DSG2, DSP, JUP, PKP2, RYR2, TGFβ3 and TMEM43 genes to confirm a diagnosis of Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy (ARVD/C) in probands.  
  - For a known familial sequence variant in the DSC2, DSG2, DSP, PKP2 or TMEM43 gene for at-risk relatives of probands with International Task Force (ITF)-confirmed ARVD/C to confirm a diagnosis of ARVD/C in those whose symptoms meet the ITF diagnostic criteria. |
| EGFR                                                               | 81235          |  
  - To help guide administration of Epidermal Growth Factor Receptor (EGFR) TKIs in the first-line treatment of non-small cell lung cancer. |

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Figure 5.2
### TRICARE guidelines for Laboratory Developed Test (LDT)

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<tr>
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<tr>
<td>F2</td>
<td>81240 81400</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnostic evaluation of beneficiaries with a prior Venous Thromboembolism (VTE) during pregnancy or puerperium.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For beneficiaries with VTE with a personal or family history of recurrent VTE (more than two in the same person).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For beneficiaries with their first VTE before age 50 with no precipitating factors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For venous thrombosis at unusual sites such as the cerebral, mesenteric, portal or hepatic veins.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For VTE associated with the use of estrogen-containing oral contraceptives, Selective Estrogen Receptor Modulators (SERMs) or Hormone Replacement Therapy (HRT).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To diagnose an inherited thrombophilia in female family members of beneficiaries with an inherited thrombophilia if the female family member is pregnant or considering pregnancy or oral contraceptive use.</td>
</tr>
<tr>
<td>FBN1</td>
<td>81408</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To facilitate the diagnosis of Marfan syndrome inpatients who do not fulfill the Ghent diagnostic criteria, but have at least one major feature of the condition.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To facilitate the diagnosis of Marfan syndrome in the at-risk relatives of patients carrying known disease-causing variants.</td>
</tr>
<tr>
<td>FLCN</td>
<td>81479</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To confirm a diagnosis of Birt–Hogg–Dubé (BHD) syndrome inpatients with suspected BHD.</td>
</tr>
<tr>
<td>FLT3</td>
<td>81245 81246</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For diagnosis and prognosis in AML.</td>
</tr>
<tr>
<td>F5</td>
<td>81241 81240</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>• To facilitate the diagnosis of Marfan syndrome in the at-risk relatives of patients carrying known disease-causing variants.</td>
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<tr>
<td>FMR1</td>
<td>81243 81244</td>
<td>FMR1 gene testing is covered for the following indications:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Testing for CGG repeat length for diagnosis of patients of either sex with mental retardation, intellectual disability, developmental delay or autism.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FMR1 gene testing for Fragile X-Associated Tremor/Ataxia Syndrome is covered for the following individuals:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Women with unexplained Premature Ovarian Insufficiency (POI).</td>
</tr>
</tbody>
</table>

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## TRICARE guidelines for Laboratory Developed Test (LDT)

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<tr>
<td>GCK</td>
<td>81406</td>
<td>• Diagnosis of Maturity-Onset Diabetes of the Young Type 2 (MODY2) inpatients 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.</td>
</tr>
<tr>
<td>GJB2</td>
<td>81252 81253</td>
<td>• Diagnosis of DFNB1 or DFNA3 in individuals with nonsyndromic hearing loss to aid in treatment.</td>
</tr>
<tr>
<td>GJB6</td>
<td>81254</td>
<td>• Diagnosis of DFNB1 or DFNA3 in individuals with nonsyndromic hearing loss to aid in treatment.</td>
</tr>
</tbody>
</table>
| HBA1/HBA2 | 81257 81404 81405 | • To confirm the diagnosis of alpha-thalassemia in a symptomatic beneficiary.  
• 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 beneficiaries with low hexosaminidase A levels in blood. When beneficiaries 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 beneficiaries 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) inpatients 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 beneficiaries refractory to treatment due to alloimmunization.  
• Diagnosis of celiac disease in symptomatic beneficiaries with equivocal results on small bowel biopsy and serology or in previously symptomatic beneficiaries who are asymptomatic while on a gluten-free diet.  
• Testing for the HLA-B*1502 allele prior to initiating treatment with carbamazepine in beneficiaries from high-risk ethnic groups.  
• Testing for the HLA-B*5701 allele for hypersensitivity reactions in beneficiaries prior to initiation or re-initiation with treatments containing abacavir.  
• Testing for the HLA-B*58:01 allele in beneficiaries 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. |
| IGH | 81261 81262 81263 | • For medical management of patients with Acute Lymphoblastic Leukemia (ALL) through analysis of rearrangements in the IGH gene to estimate Minimal Residual Disease (MRD) levels.  
• For diagnostic evaluation of rearrangements in the IGH gene inpatients with suspected B-cell Non-Hodgkin’s Lymphoma (NHL), but in whom clinical, immunophenotypic and histologic evaluation have provided inconclusive results. |
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</table>
| IGK | 81264          | • For medical management of patients with ALL through analysis of rearrangements in the IGK gene to estimate MRD levels.  
• For diagnostic evaluation of rearrangements in the IGK gene inpatients with suspected B-cell NHL, but in whom clinical, immunophenotypic and histologic evaluation have provided inconclusive results. |
| JAK2 | 81270 81403 | • Diagnostic evaluation of beneficiaries 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 beneficiaries. |
| KCNQ1, KCNH2, SCN5A, KCNE1 & KCNE1 | 81280 81281 81282 | • For patients with suspected familial Long QT Syndrome for confirmation of diagnosis and treatment. |
| KIT | 81272 81273 | • To confirm a diagnosis of a Gastrointestinal Stromal Tumor (GIST) inpatients who are negative by immunostaining.  
• To determine primary resistance to treatment with TKIs inpatients with an advanced metastatic or unresectable GIST.  
• To determine primary resistance to preoperative or postoperative treatment of a GIST with TKIs. |
| KRAS | 81275 81276 | • To help guide administration of anti-EGFR monoclonal antibodies. |
| MECP2 | 81302 81303 81304 | • Testing for MECP2 sequence variants in beneficiaries who meet established clinical diagnostic criteria for classic or variant Rett Syndrome (RS).  
• Testing for MECP2 sequence variants in beneficiaries 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 benes showing symptoms. |
| Noninvasive prenatal screening for trisomies 13, 18, 21, X & Y | 81420 81479 81507 81599 | • In singleton pregnancies with a high-risk of fetal aneuploidy. |
| NPM1 | 81310 | • To guide treatment decisions for beneficiaries with AML. |
| NRAS | 81311 | • 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. |
| 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. |

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<td>PAX8</td>
<td>81401</td>
<td>• For beneficiaries with indeterminate thyroid FNA biopsy cytology for diagnosis of papillary thyroid carcinoma.</td>
</tr>
<tr>
<td>PDGFRA</td>
<td>81314</td>
<td>• To confirm a diagnosis of a GIST inpatients who are negative by immunostaining.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To determine primary resistance to treatment with TKIs inpatients with an advanced metastatic or unresectable GIST.</td>
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<tr>
<td></td>
<td></td>
<td>• To determine primary resistance to preoperative or postoperative treatment of a GIST with TKIs.</td>
</tr>
<tr>
<td>PML/RARalpha</td>
<td>81315 81316</td>
<td>• Diagnostic assessment of beneficiaries with suspected acute promyelocytic leukemia (APL) by quantitative RT-PCR (RQ-PCR).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnostic assessment of beneficiaries with suspected APL by qualitative RT-PCR.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Monitoring response to treatment and disease progression in benes with APL by RQ-PCR.</td>
</tr>
<tr>
<td>PMP22</td>
<td>81324 81325 81326</td>
<td>• For the accurate diagnosis and classification of hereditary polyneuropathies.</td>
</tr>
<tr>
<td>PPP2R2B</td>
<td>81401</td>
<td>• Diagnosis of Spinocerebellar Ataxia Type 12 (SCA12) inpatients 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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of SCA12 in symptomatic family members of known SCA12 patients.</td>
</tr>
<tr>
<td>PRSS1</td>
<td>81401</td>
<td>To confirm a diagnosis of hereditary pancreatitis in symptomatic patients with any of the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A family history of pancreatitis in a first-degree (parent, sibling, child) or second-degree (aunt, uncle, grandparent) relative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recurrent (two or more separate, documented episodes with hyperamylasemia) 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.).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unexplained (idiopathic) chronic pancreatitis.</td>
</tr>
<tr>
<td>PTEN</td>
<td>81321 81322 81323</td>
<td>• For beneficiaries with ASDs and macrocephaly (Head circumference greater than 2 standard above the mean for age).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• PTEN variant testing in beneficiaries suspected of being affected with Cowden Syndrome (CS) or Bannayan-Riley-Ruvalcaba Syndrome (BRRS).</td>
</tr>
<tr>
<td>RET</td>
<td>81404 81405</td>
<td>• Multiple endocrine neoplasia type 2 (MEN2) gene testing in beneficiaries with the clinical manifestations of MEN2A, MEN2B or familial medullary thyroid carcinoma (FMTC), including those with apparently sporadic Medullary Thyroid Carcinoma (MTC) or pheochromocytoma.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MEN2 gene testing to confirm a diagnosis in the at-risk relatives of genetically confirmed MEN2 beneficiaries.</td>
</tr>
<tr>
<td>ROS1</td>
<td>88274</td>
<td>• For patients who have wild type (negative) EGFR or ALK gene testing, reflex testing to ROS1 should be ordered for the treatment of non-small cell lung carcinoma.</td>
</tr>
</tbody>
</table>

Codes listed are taken from *TRICARE Operations Manual, Chapter 18; Sections 13 & 17*. Figure 5.2

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| 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 inpatients with PGLs and/or PCCs. |
| SDHD | 81404          | • To diagnose a hereditary PGL or PCC syndrome inpatients with PGLs and/or PCCs. |
| SERPINA1 | 81332 | • For guidance in diagnosis of inconclusive cases of Alpha-1 Antitrypsin Deficiency (AATD) in individuals with Chronic Obstructive Pulmonary Disease (COPD), unexplained liver disease, family history of AATD or environmental exposures leading to airflow obstruction after serum Alpha-1 Antitrypsin (AAT) protein levels and protein phenotyping has been completed. |
| SMAD4 | 81405 81406   | • To clarify the diagnosis of beneficiaries 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 beneficiaries with hypotonia and muscle weakness who are suspected of having Spinal Muscular Atrophy (SMA). |
| 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 beneficiaries with developmental delay, regardless of age.  
• As part of the evaluation of beneficiaries 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 beneficiaries 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 beneficiaries with a presumptive or probable diagnosis of PJS. |

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| 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 inpatients suspected of having Huntington Disease (HD) who have tested negative for a pathogenic variant in the HD gene. |
| TPS3| 81404 81405    | • Diagnosis of benes 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 inpatients with CRC to lower the starting dose of irinotecan inpatients with the UGT1A1*28/UGT1A1*28 genotype.  
  • Prior to irinotecan administration inpatients with CRC to increase the starting dose of irinotecan inpatients with the UGT1A1*1/UGT1A1*1 or UGT1A1*1/UGT1A1*28 genotypes. |
| VHL | 81403 81404    | • Diagnosis of Von Hippel-Lindau (VHL) syndrome in beneficiaries presenting with pheochromocytoma, paraganglioma or central nervous system hemangioblastoma.  
  • Confirmation of diagnosis in beneficiaries with symptoms consistent with VHL syndrome. |
| VKORC1 | 81355     | • For the initiation and management of Warfarin treatment. |

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Please be aware codes are only as current as the date of this document.

TRICARE 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 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 provider self-service at HumanaMilitary.com

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

Submit by phone
1-800-444-5445

Behavioral healthcare referrals and authorizations may also be submitted via provider self-service, fax at 1-877-378-2316 or by phone at 1-800-444-5445.

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 through the Right Of First Refusal (ROFR) process
• 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
MEDICAL COVERAGE & HEALTHCARE MANAGEMENT

• Check the status of the referral or authorization at HumanaMilitary.com or by phone at 1-800-444-5445
• Access provider self-services at HumanaMilitary.com for guides outlining clinical information required to expedite requests for the ECT, TMS, outpatient substance abuse treatment programs and applied behavioral analysis
• Humana Military will notify the beneficiary and providers of an approved referral or authorization

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. Log in to provider self-service, 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 behavioral healthcare admissions, submit notification online at HumanaMilitary.com. This is the quickest and most convenient way to notify Humana Military of a hospital admission. Facilities unable to access/submit online can fax the admission request to Humana Military at 1-877-548-1547.

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

Prior authorization requirements in the East Region

Procedures and services:
• Adjunctive dental care
• Advanced life support air ambulance in conjunction with stem cell transplantation
• Bariatric surgery
• Extended Care Health Option (ECHO) services
• Home health services, including home infusion
• Hospice
• Laboratory Developed Tests (LDTs)
• Open, arthroscopic and combined hip; Surgical for the treatment of Femoroacetabular Impingement (FAI)
• Spinal fusion and related procedures
• Transplants (solid organ and stem cell, not corneal transplant)

Inpatient stays:
• Acute care admissions (Notification of acute care admission is required by the next business day)
• Admissions or transfers to Skilled Nursing Facilities (SNFs), rehabilitation and Long-Term Acute Care (LTAC)
• Continued stay review
• Discharge notification

Behavioral health:
• Applied Behavior Analysis (ABA)
• Comprehensive Autism Care Demonstration (CACD)
• Electroconvulsive Therapy (ECT)
• Non-emergency admissions, to include detoxification & rehabilitation services
• Psychoanalysis
• Residential Treatment Centers (RTCs)
• Transcranial Magnetic Stimulation (TMS)

Behavioral health concurrent review:
• Emergency admissions
• Intensive Outpatient Program (IOP)
• Opioid Treatment Program (OTP)
• Partial Hospital Program (PHP)

List is subject to change. Please refer to provider and provider charts under provider resources on HumanaMilitary.com
Right Of First Refusal (ROFR)

Military hospitals and clinics have the Right Of First Refusal (ROFR) to provide care for a TRICARE beneficiary.

Tips for ensuring the ROFR process is working in your office:
- Build/request referrals using the options available to your office at HumanaMilitary.com or by faxing a referral/authorization request using the Patient Referral Authorization Form (PRAF)
- Understand that even if you select a provider to refer to, the local military hospital or clinic may review and override the referral selection
- Ensure the beneficiary is aware the military hospital or clinic may take precedence on the referral selection

Military hospitals and clinics and ROFRs

Military hospitals and clinics are located on most military posts, bases and installations. Their primary focus is active duty readiness for military contingency operations. The military hospital or clinic is also responsible for TRICARE families and may choose to have Prime-referred services delivered within the military hospital or clinic for a number of reasons:
- To enhance the military graduate medical education program
- To hone the skills of military providers rotating through the military hospital or clinic nearest you
- To ensure military hospital and clinic optimization, which helps to contain healthcare cost for TRICARE beneficiaries
- To assist in determining prevalent military hospital and clinic specialty access and adequacy needs for a particular TRICARE population

The ROFR process

In accordance with the TRICARE Operations Manual, Chapter 8, Section 5.1, “The referral request for beneficiaries residing within the PRIME Service Area shall follow the Right Of First Refusal allowing the local military hospital or clinic priority. Access standards, enrollment category, available specialty, as well as diagnosis and requested services/procedures are considered affording the military hospital the opportunity to see the patient....”

After it is determined a beneficiary needs to be referred for specialty care, the requesting provider will submit a referral/authorization request via web or fax to Humana Military for approval and ROFR processing.

Many times the military hospital or clinic will have the specialized services available. In this scenario, the military hospital or clinic will notify us, usually within one business day, and the beneficiary will be referred to the military hospital or clinic. The military hospital or clinic may contact the beneficiary to schedule an appointment, and Humana Military will provide the beneficiary with the information for contacting the military hospital or clinic.

If the military hospital or clinic cannot provide the services or care requested, the patient will be referred to a civilian network provider. However, it is important to understand if a provider is selected prior to the ROFR determination and the military hospital or clinic can provide the services, and accepts the care, this overrides any prior provider selection requiring the beneficiary to be seen at the military hospital or clinic.

*Approved to military hospitals or clinic for available service or approval to civilian provider if military hospital or clinic service is not available.
**Autofax confirmation**

The PCM and the referred-to provider will receive an automatic fax when care is authorized. Authorization, however, is not a guarantee for payment.

The automatic fax will specify the services authorized, the number of visits and the period in which the visits must occur. The beneficiary will also receive notification of the approved referral or authorization.

Providers should program their office/referral fax number into their fax machine to ensure the number appears on their referral requests.
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, by submitting necessary clinical information, 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 traumas
- 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 (TQMC)

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 (PRO) 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 who 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 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 (PRO) agreement

Humana Military has review authority over healthcare services provided in civilian facilities to MHS beneficiaries in the TRICARE East 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 Code of Federal Regulations, (CFR) 199.2, 199.6, 199.15 [g] and TRICARE Operations Manual, 6010.59-M, April 1, 2015, Chapter 7, Section 1, 4.0.). For more information, refer to the TRICARE Operations Manual, Chapter 7, Section 1, 4.0 at manuals.TRICARE.osd.mil

The PRO Agreement is separate from a network contract and network and non-network facilities are required to sign one. The agreement is a signed acknowledgement that Humana Military is the PRO for the TRICARE East Region.

If a corporation has multiple facilities, one signed agreement may cover all the facilities. Please attach a list that includes each facility and its respective tax ID and group NPI number.

The PRO Agreement confirms that the facility will cooperate with Humana Military and its subcontractors by:

• Providing copies of medical records
• Providing accurate information on patients’ conditions
• Informing patients of their rights and responsibilities
• Providing other assistance that may be required for Humana Military to conduct comprehensive utilization and quality management programs for care of MHS beneficiaries who are patients of the facility
Peer Review Organization agreement for institutional providers for beneficiaries of the military health system

The institution will cooperate with Humana Military and its subcontractors by providing copies of medical records; providing accurate information on patient’s conditions; informing patients of their rights and responsibilities; and providing other assistance that may be required for Humana Military to conduct comprehensive utilization and quality management programs for care of Military Health Systems (MHS) beneficiaries who are patients of the institution.

The institution will provide adequate space for conducting on-site review or provide review information telephonically or electronically to Humana Military or its subcontractors. The institution will deliver to Humana Military or its subcontractors, within 30 days or earlier if requested, of receipt of written request, copies of information required for off-site review of care provided by the institution to beneficiaries who are patients of the institution. Reimbursement for the costs of photocopying and postage will be the same reimbursement as current Medicare rate, as amended from time to time.

The institution will provide all MHS beneficiary patients written information on their rights and responsibilities (e.g. “An Important Message from TRICARE”) and, when appropriate, a proper hospital issued notice of noncoverage.

The institution will inform Humana Military at 1-800-334-5612 within three working days if they issue a notice that the beneficiary patient no longer requires inpatient care.

The institution will ensure that each case subject to preadmission/preprocedure review has been reviewed and approved by Humana Military.

Institutional providers will agree, when they fail to obtain certification as required, that they will accept full financial liability for any admission subject to preadmission review that was not reviewed and is subsequently found to be medically unnecessary or provided at an inappropriate level (32 CFR 199.15(g)).

The institution acknowledges that Humana Military has provided it with detailed information on the utilization and quality review processes and criteria used and the potential financial liability incurred by failing to obtain prior authorization when required.

<table>
<thead>
<tr>
<th>Institution name</th>
<th>Tax ID number</th>
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<tbody>
<tr>
<td>Signature</td>
<td>Group NPI number</td>
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<td>Title</td>
<td>Address</td>
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<td>Date</td>
<td>Suite or building</td>
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<td>City/State/ZIP</td>
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</tbody>
</table>

Please complete the required information above and return via fax @ 855-509-2808 or mail Humana Military Utilization Management, P.O. Box 740044 Louisville, KY 40201-7444.
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.

<table>
<thead>
<tr>
<th>Where to send appeals for denied referrals or authorizations</th>
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<tbody>
<tr>
<td><strong>Prior authorization appeals</strong></td>
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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
This section of the TRICARE provider handbook provides information about behavioral health benefits and services. Although it is not all-inclusive, primary source documents are referenced in each section for providers who want to learn more about a particular area or topic. See the other sections of this handbook for additional information to assist you in caring for TRICARE beneficiaries.

At the time of publication, the information contained in this chapter is current. However, the TRICARE program continually evolves as federal regulations are revised and updated. To help ensure compliance with procedures, policies and program requirements, providers should consult the TRICARE manuals found at manuals.TRICARE.osd.mil

### Covered services information

TRICARE covers services delivered by qualified, TRICARE-authorized behavioral healthcare providers practicing within the scopes of their licenses, to diagnose and/or treat covered behavioral health disorders. All services and supplies provided by unauthorized providers are excluded. For information about the requirements for being an authorized TRICARE provider, refer to the TRICARE Policy Manual, Chapter 11.

TRICARE beneficiaries are encouraged to receive behavioral healthcare from a military hospital or clinic. However, access may be limited due to space-availability issues or the military hospital or clinic’s ability to render the care needed. When a service is not available at an military hospital or clinic, beneficiaries may seek behavioral healthcare from an authorized provider and, preferably, a network provider. For additional information about networking criteria, visit join the network at HumanaMilitary.com

To be considered a covered condition, behavioral conditions must meet the following criteria:

- The condition must be listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- The symptoms are of a severity to cause significant distress
- The condition interfere with the patient’s ability to carry out his or her usual activities

Services and supplies that are not considered medically or psychologically necessary are generally excluded. To determine if a specific service is a covered benefit or if coverage is limited, use the code look up feature via provider self-service. See the chart below for an overview of the special rules and limits for TRICARE-covered benefits and services.
## Covered outpatient and inpatient services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage details</th>
<th>Referral/authorization requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute hospital psychiatric care</strong></td>
<td>Brief, intensive treatment used to stabilize life-threatening or severely disabling conditions, including medical stabilization and treatment of complications of SUD, to permit management of the beneficiary’s condition at a less intensive level of care.</td>
<td>• Prior authorization for emergency admission not required. Admissions must be reported to Humana Military within 24-72 hours • Concurrent review required for continuation of inpatient care • Preadmission and continued stay authorization is required for all nonemergency admissions</td>
</tr>
</tbody>
</table>
|                                             | • Emergency admission criteria:  
  • Patient is immediate risk of serious harm to self or others based on a psychiatric evaluation by physician (or other qualified behavioral health professional) with hospital admission authority  
  • Patient requires immediate continuous skilled observation and treatment  

• Non-emergency admission criteria:  
  • Patient needs 24-hour basis assessment and observation from skilled nursing staff  
  • Patient requires continued intervention by a multidisciplinary treatment team and meets one or more of the following:  
    • Serious risk of harm to self or others  
    • Needs high dosage, intensive medication or somatic/psychological treatment, with potentially serious side effects  
    • Has acute disturbance of mood, behavior or thinking  

| **Applied Behavior Analysis (ABA)**         | The CACD covers ABA services for eligible beneficiaries with a diagnosed Autism Spectrum Disorder (ASD) using DSM-5 criteria and issued a referral for ABA services by a TRICARE-authorized Physician-Primary Care Manager (P-PCM) or by a specialized ASD-diagnosing provider. ADSMs must be enrolled in the Exceptional Family Member Program (EFMP) and registered for Extended Care Health Option (ECHO).  
  • Authorizations cover one-to-one services and tiered delivery services, depending upon the unique needs of the beneficiary.  

| **Eating disorder programs**                | Medically necessary and appropriate inpatient or outpatient treatment for patients diagnosed with an eating disorder  
  • Inpatient eating disorder care must be provided in a Residential Treatment Center (RTC), Partial Hospitalization Program (PHP) or other authorized institutional provider  
  • Outpatient eating disorder care must be rendered by a TRICARE-authorized individual professional provider  

| **Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS)** | TMS is covered only for the treatment of major depressive disorder.  
  Exclusions:  
  • TRICARE does not cover the use of electric shock as negative reinforcement (aversion therapy)  

| **Opioid replacement treatment**            | Opioid replacement treatment involves the substitution of a therapeutic drug with addictive potential for a drug of addiction  

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For more information, review TRICARE Policy Manual Chapter 7, except for ABA and CACD see TRICARE Operations Manual, Chapter 18, Section 4
**Covered inpatient and outpatient services**

<table>
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</table>
| Partial Hospitalization Programs (PHPs) | Interdisciplinary therapeutic services provided at least three hours per day, five days per week in any combination of day, evening, night and weekend. May also provide Intensive Outpatient Programs (IOPs) involving partial hospitalization services less than five days per week, at least three hours per day (but less than six hours per day). | • Preadmission and continued stay authorization required, even if the facility is transferring a patient to a lower level of care within its own structure  
  • To be authorized, PHPs are required to address the feasibility of family therapy as treatment plan |
|                                      | Appropriate treatment for:  
  • Crisis stabilization  
  • Treatment of partially stabilized behavioral health disorders  
  • Transition from an inpatient program | | |
|                                      | Admission criteria:  
  • Patient has significant impairment interfering with age appropriate functioning  
  • Patient unable to function in the community with appropriate support or not at a sufficient level of functioning to permit adequate course of therapy exclusively on an outpatient basis (but is able, with appropriate support, to maintain a basic level of functioning to permit partial hospitalization services) | | |
| Psychological testing and assessment  | Covered when provided in conjunction with psychotherapy or as a required part of the assessment and reassessment process for Applied Behavior Analysis (ABA) under the Comprehensive Autism Care Demonstration (CACD). | • Required after first six hours per fiscal year (October 1 to September 30)).  
  • Required for outcome evaluations (initial and two year review) under CACD  
  • Required for ABA assessment (initial and six month follow-up) under CACD |
|                                      | Exclusions:  
  • Reitan-Indiana battery for a patient under age five  
  • Self-administered tests to patients under age 13  
  • Testing as part of assessment for academic placement | | |
| Psychotherapy                        | Covered inpatient/outpatient psychotherapy visits to treat behavioral health and substance use disorders:  
  • Individual, group, family and conjoint psychotherapy  
  • Collateral visits  
  • Crisis intervention  
  • Play therapy  
  • Eye Movement Desensitization and Reprocessing (EMDR)  
  • Psychoanalysis | • Not required for collateral visits on same day as therapy  
  • Prior authorization required for psychoanalysis | |
|                                      | Limits:  
  • Sessions cannot be combined  
  • Only one session of a particular type can be charged on the same day, except for collateral visits on the same day patient receives individual or group therapy  
  • Outpatient visits are not covered when patient is receiving inpatient care  
  • Play therapy only for children  
  • EMDR only for adults with Post Traumatic Stress Disorder (PTSD)  
  • Psychoanalysis only if provider is graduate/candidate of American Psychoanalytic Association recognized training institution. | | |

For more information, review TRICARE Policy Manual Chapter 7, except for ABA and CACD see TRICARE Operations Manual, Chapter 18, Section 4
## Covered outpatient and inpatient services

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</thead>
<tbody>
<tr>
<td><strong>Psychotropic pharmacological management</strong></td>
<td>• Coverage includes prescriptions and review of medication, when performed with or without psychotherapy services.</td>
<td>• Required</td>
</tr>
<tr>
<td><strong>Residential Treatment Center (RTC)</strong></td>
<td>• Elective and non-emergency treatment for children up to age 21 who require care due to a serious behavioral health disorder&lt;br&gt;Admission criteria: • A psychiatrist or clinical psychologist must recommend the child be admitted to the RTC, and a psychiatrist or clinical psychologist must direct the development of a treatment plan • Patient exhibits patterns of disruptive behavior with evidence of disturbances in family functioning or social relationships and persistent psychological and/or emotional disturbances • Active involvement of family and/or guardian, unless therapeutically contraindicated. The facility must document its plans for including the family in therapy.</td>
<td>• Prior authorization required and should be made at least two business days prior to planned admission (prior authorization is valid for 90 days) • Concurrent review of necessity for continued stay is conducted at least every 30 days</td>
</tr>
<tr>
<td><strong>Telemedicine</strong></td>
<td>• Facilitates the exchange of medical information (e.g., medical images and output data from medical devices and verbal diagnostic information) between providers and/or providers and patients through electronic means, including live two-way audio and video modalities (e.g., Clinical Video-Teleconferencing (VTC) between patients at the “originating site” and providers at the “distant site”) • Ancillary services (e.g., laboratory tests, Durable Medical Equipment (DME)) may be ordered/prescribed in conjunction with a telemedicine visit to the same extent as during an in-person visit&lt;br&gt;Exclusions/limitations: • Christian science services • Audio-only telephone services • All ancillary services must conform to TRICARE regulation(s) and state law(s) at both the originating site and the patient’s location.</td>
<td>• Any applicable referral and/or prior authorization requirements that apply for services under the TRICARE program also apply when such services are delivered via telemedicine</td>
</tr>
</tbody>
</table>

For more information, review [TRICARE Policy Manual Chapter 7](#), except for ABA and CACD see [TRICARE Operations Manual, Chapter 18, Section 4](#).
Noncovered conditions and treatment

All services and supplies related to a noncovered condition or treatment 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 noncovered services by signing the TRICARE Non-covered Services Waiver form. To obtain specific information on TRICARE policy, benefits and coverage, please consult the TRICARE Policy Manual or TRICARE Reimbursement Manual or the code look up feature on provider self-service.

Those include:

• Aversion therapy (e.g. electric shock and use of chemicals for alcoholism, except disulfiram, which is covered for the treatment of alcoholism)
• Behavioral healthcare services and supplies related solely to obesity and/or weight reduction
• Biofeedback for psychosomatic conditions
• Counseling services that are not considered medically necessary in the treatment of a diagnosed medical condition. (i.e. nutritional counseling, stress management, marital therapy, or lifestyle modifications)
• Custodial care
• Educational programs
• Experimental procedures
• Inpatient stays primarily for rest or rest cures
• Megavitamin or orthomolecular therapy
• Psychoanalysis or psychotherapy provided to a beneficiary or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may be present
• Sedative action electrostimulation therapy
• Services and supplies above the appropriate level required to provide necessary care
• Services and supplies related to an inpatient admission that could have been and are performed routinely on an outpatient basis
• Services and supplies that are (or are eligible to be) payable under another medical insurance or program (including private or governmental, such as coverage through employment or Medicare)
• Sex therapy, sexual advice, sexual counseling, sex behavior modification, or psychotherapy and any supplies provided in connection with therapy for sexual dysfunctions, inadequacies, or paraphilic disorders
• Stellate ganglion block for the treatment of Post-Traumatic Stress Disorder
• Therapy for developmental disorders (including dyslexia, language, mathematics disorders and articulation disorders)
• Therapeutic absences from inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE

Note: For a complete list of behavioral healthcare services that are excluded under TRICARE or are covered with significant limitations, visit TRICARE.mil

Referral and authorization requirements

TRICARE prior authorization and referral requirements vary according to beneficiary type, program option, diagnosis and type of care. Referral and prior authorization requirements for specific services can be found on the following pages. For general requirements, please see below.

• Active duty service members (ADSMs): Should receive behavioral healthcare at a military hospital or clinic whenever possible and must have prior authorizations and/or referrals from their primary care manager (PCM) and Humana Military before seeking non-emergency behavioral healthcare.

• Dual-eligible beneficiaries: Beneficiaries using Medicare as their primary payer may self-refer to any network or non-network behavioral health provider who accepts Medicare; referrals and/or prior authorization from Humana Military is not required. Beneficiaries should follow Medicare rules for services requiring authorization. When behavioral healthcare benefits are exhausted under Medicare, TRICARE becomes the primary payer, and prior authorization from Humana Military is then required.

Obtaining referrals and prior authorizations

Registered providers should use provider self-service to submit all referrals and prior authorization requests.

Note: When using provider self-service to submit requests for one of following services, please use the appropriate checklist (HumanaMilitary.com/provider/resources/#forms) to ensure that all necessary clinical information is included with your request:

• Applied Behavior Analysis (ABA) Assessment and Treatment Plan (TP)
• Comprehensive Autism Care Demonstration (CADC) service request
• Electroconvulsive Therapy (ECT)treatment request
• Outpatient/ambulatory Opiate and Substance Use Disorder (SUD)treatment request
• Transcranial Magnetic Stimulation (TMS) treatment request

Providers who are unable to submit requests online should complete the appropriate form (HumanaMilitary.com/provider/resources/#forms) and fax it to 1-877-378-2316 or call 1-800-444-5445.
### Expectations and standards for care

**Awareness of risks and symptoms of common disorders**

Military life, especially the stress of deployments or mobilizations, can present challenges to service members and their families that are both unique and difficult. Primary Care Managers (PCMs) are generally the frontline of support for beneficiaries. However, all TRICARE providers play a critical role in early detection and intervention. It is important that providers are aware of the risks and symptoms of the following:

- Depression
- Posttraumatic Stress Disorder (PTSD)
- Suicide
- Traumatic Brain Injury (TBI)

Visit [HumanaMilitary.com](https://www.HumanaMilitary.com) to learn more about these and other behavioral health conditions.

**Care management**

The coordination of care between behavioral health providers and primary care managers (PCMs) is a high priority. The PCM and specialty care provider should coordinate with Humana Military as needed to ensure the highest quality care.

<table>
<thead>
<tr>
<th>PCM responsibilities</th>
<th>Specialty care provider responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Render care for acute illness, minor accidents and follow-up care for on-going medical problems as authorized in the TRICARE Prime benefits plans.</td>
<td>• Follow TRICARE procedures and requirements for services that require prior authorization or a referral (access provider self-service to review services and submit requests).</td>
</tr>
<tr>
<td>• Ensure access to necessary healthcare services, as well as any specialty requirements, if the PCM cannot provide services.</td>
<td>• Accepts the TRICARE allowable charge as payment in full for a covered service.</td>
</tr>
<tr>
<td>• Provide access to care 24 hours a day, seven days a week, including after-hours and urgent care or arranging for on-call coverage by another provider. Note: The on-call provider must notify the PCM within 24 hours of an inpatient admission to ensure continuity of care.</td>
<td>• Notify Humana Military of emergency inpatient admission within 24 hours, or by the next business day, via provider self-service or by faxing the patient’s hospital admission record face sheet (including beneficiary’s demographic information, health plan information, name of the admitting physician and admitting diagnosis and date) to 1-877-378-2316.</td>
</tr>
<tr>
<td>• Referring patients for specialty care and obtaining prior authorizations and referrals, when required, from Humana Military.</td>
<td>• Provide Clear and Legible Reports (CLRs), which include specialty care consultation/referral reports, brief initial assessments, notes on the episode of care and discharge summaries to the referring PCM within seven business days of care delivery.</td>
</tr>
<tr>
<td>• Determining the level of care needed:</td>
<td>• Reports should contain the patient’s first name, middle initial, last name, date of birth and the last four digits of the sponsor’s social security number.</td>
</tr>
<tr>
<td>• <strong>Urgent care</strong>: Instructing the patient to contact the PCM’s office on the next business day to schedule an appointment.</td>
<td>• In emergency situations, a preliminary report of a specialty consultation should be provided to the referring provider by telephone or fax within 24 hours. Telephonic reports should be followed up with a CLR within seven business days of the urgent/emergent care.</td>
</tr>
<tr>
<td>• <strong>Routine care</strong>: Coordinating timely care for the patient.</td>
<td></td>
</tr>
</tbody>
</table>

**Clinical practice guidelines**

Humana Military supports quality in clinical practice by providing access to current, evidence-based resources, including continuing education, screening tools and toolkits. Providers are encouraged to review these guidelines and to incorporate these standards into their own practice. Guidelines and other resources can be found at [HumanaMilitary.com](https://www.HumanaMilitary.com)

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**Figure 6.2**
Expectations and standards for care

**Discharge planning and post-hospital follow-up**

Effective discharge planning ensures the beneficiary's safe and timely transition from one level of care to another and documents the services he or she will receive after discharge. The risk of relapse should be mitigated by arranging a timely post-discharge appointment.

Discharge planning begins at the onset of treatment, when the provider anticipates the discharge date and forms an initial impression of the beneficiary's post-discharge needs (including arrangements for outpatient services or coordinating transfers to lower levels of care) and continues throughout the hospital stay.

The initial discharge plan may evolve in response to changes in the beneficiary's condition and his or her preferences. The final discharge plan should document the following:

- Anticipated discharge date and the proposed post-discharge services
- The plan to coordinate discharge with the provider at the next level of care, when indicated
- The plan to reduce the risk of relapse, such as by confirming that the beneficiary understands and agrees with the discharge plan
- The scheduled follow-up appointment date and time
- The provider's name, address and phone number
- The best contact phone number for the beneficiary immediately after discharge

To ensure that beneficiaries have access to appropriate treatment following discharge from inpatient care:

- An outpatient appointment must be scheduled by the facility and offered by the outpatient provider within seven days of an acute inpatient discharge
- The inpatient provider or designee must provide a written or verbal summary of the beneficiary's needs to the receiving outpatient provider prior to discharge, to coordinate continuity of care

**Incident reporting**

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 Humana Military within one business day. TRICARE participation agreements outline specific requirements for reporting occurrences, as defined by TRICARE, including:

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

**Updating provider information**

- The provider locator tool, located at [HumanaMilitary.com](http://HumanaMilitary.com) helps beneficiaries and other providers find TRICARE network providers. Keeping your information up to date ensures that TRICARE beneficiaries and other providers have your current contact information.
- Network providers may use provider self-service to keep their information current. The provider locator tool does not include non-network providers.

**Provider resources and tools**

In addition to the provider handbook, Humana Military offers TRICARE East Region providers the following resources and tools to support the behavioral healthcare needs of TRICARE beneficiaries.

**HumanaMilitary.com**

The provider behavioral healthcare section of our website provides access to:
- Information about important behavioral health topics
- Provider newsletters
- Seminars and continuing education opportunities
- Important updates
- Behavioral health forms
- And more

**Autism Center of Excellence (CoE)**

The Autism CoE is designed to give beneficiaries and providers a place to access accurate and timely information about living with Autism Spectrum Disorder (ASD). The content is maintained by our behavioral healthcare team and aims to create value by achieving improvement in outcomes through clinical, educational and research activities. Information that can be found at the autism CoE includes:

- Guidance regarding structured documentation (electronic health record)
- Clinical practice guidelines
- Process and outcome measures
- Educational materials
- Innovation and identification of research priorities
- Strategies for improving access to care

Figure 6.2
Claims processing standards

TRICARE requires providers to file claims electronically with the appropriate HIPAA-compliant standard electronic claims format. Non-network providers submitting paper claims must use either a CMS-1500 (professional charges) or a UB-04 (institutional charges) claim form.

The NPI is a 10-digit number used to identify providers in standard electronic transactions. It is a HIPAA requirement. Providers must submit the appropriate NPI on all HIPAA-standard electronic transactions. Both billing NPIs and rendering provider NPIs, when applicable, are required when filing claims. Providers treating TRICARE beneficiaries as a result of referrals should also include the referring provider’s NPI on transactions, if available, per the implementation guide for the transaction.

Both individual providers (Type 1) and organizational providers (Type 2) should register all NPIs with Humana Military. The easiest way to do this is via provider self-service.

HIPAA transaction standards and code sets

Providers must use the following HIPAA standard formats for TRICARE claims: ASC X12N 837—Health Care Claim: Professional, Version 5010 and Errata and ASC X12N 837—Health Care Claim: Institutional, Version 5010 and Errata TRICARE contractors and other healthcare payers are prohibited from accepting or issuing transactions that do not meet HIPAA standards.

To avoid cash-flow disruptions, it is imperative that providers use the HIPAA-compliant claims formats. For assistance with HIPAA standard formats for TRICARE, call WPS Electronic Data Interchange (EDI) Help Desk at 800-782-2680 option 1.

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.

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 behavioral 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.
US Family Health Plan (USFHP)

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.

USFHP list of providers

- CHRISTUS Health, Houston, Texas (which includes):
  - St Mary’s Hospital, Port Arthur, Texas
  - St John Hospital, Nassau, Texas
  - St. Joseph Hospital, Houston, Texas
- Martin’s Point Health Care, Portland, ME
- Johns Hopkins Health Care Corporation, Baltimore, MD
- Brighton Marine Health Center, Boston, MA
- St. Vincent’s Catholic Medical Centers of New York, New York City, NY
- Pacific Medical Clinics, Seattle, WA

Processing claims for out-of-region care

When providing healthcare services to a TRICARE beneficiary who is enrolled in a different region, the beneficiary will pay the applicable cost-share and providers must submit reports and claims information to the region based on the beneficiary’s enrollment address, not the region in which he or she received care.

For claims issue or questions regarding a TRICARE patient who normally receives care in another TRICARE region, call the appropriate region-specific number for assistance.

Designated providers are facilities that have contracts with the DoD to provide care to beneficiaries enrolled in the US Family Health Plan (USFHP). USFHP is offered in six geographic regions in the United States.

Although it provides a TRICARE Prime-like benefit, USFHP is a separately funded program that is distinct from the TRICARE program administered by Humana Military. The designated provider is responsible for all medical care for a USFHP enrollee, including pharmacy services, primary care and specialty care.

If providing care to a USFHP enrollee outside of the network or in an emergency, file claims with the appropriate designated provider at one of the addresses listed. Do not file USFHP claims with Humana Military.

For more information, visit USFHP.com

Proper billing for multiple procedures

Do not use the same CPT® code billed on multiple lines for the same date of service instead of one line with multiple units. If there are multiple dates of service, each line should be billed separately.

The following are examples for billing a pathology exam on three breast biopsy specimens on the same date of service:

- **Correct way:** One line with the CPT® code and three units
- **Wrong way:** Three lines with the CPT® code with one unit each

If the claim includes three lines with one unit for each line on the same date of service, the additional lines appear as duplicates causing the additional lines to deny.

Duplicate claims

Duplicate claims occur when providers resubmit claims that have already been processed through to completion. In many instances, duplicate claims have been previously processed for payment. In other situations, claims have been processed for partial payment or possibly denied. To avoid submitting duplicate claims, providers should reconcile their financial records as soon as possible to avoid the impression of an unpaid balance.

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

**Note:** Wait at least 30 days before claims resubmission or telephone inquiry. Check the status of a claim by using the IVR system at 1-800-444-5445 or HumanaMilitary.com.

If, after reconciling your accounts, you determine payment has not been received or you disagree with the payment amount, do not resubmit the same claim. Instead, explain your circumstance or disagreement by requesting a claim review and sending written correspondence to:

TRICARE East Region claims
ATTN: Correspondence/ Corrected claims
P.O. Box 8923
Madison, WI 53707-8923
Electronic Funds Transfer (EFT)

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

Claims submission address

TRICARE East Region
Claims Department
PO Box 7981
Madison, WI 53707-7981

Hospital and facility billing

Emergency room charges in conjunction with a DRG-reimbursed hospital stay must be billed on a separate outpatient UB-04. Additionally, ambulatory surgery room charges cannot be submitted on an inpatient claim and should be billed as a separate outpatient service on the UB-04 (revenue code 049X).

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

Hospital-based outpatient surgical procedures are reimbursed under the TRICARE Outpatient Prospective Payment System (OPPS). Some hospitals are exempt from OPPS. This is mandatory for both network and non-network providers. TRICARE’s OPPS closely mirrors Medicare’s OPPS method; however, the TRICARE program determines benefits and coverage for the entire military population, regardless of age. For a list of exempt facilities, procedure code change for TRICARE’s No Government Pay List and more information regarding TRICARE OPPS implementation, refer to the TRICARE Reimbursement Manual, Chapter 13. TRICARE-OPPS exempt facilities reimburse rates established by TRICARE for outpatient surgical procedures. To ensure proper payment for procedures listed on the TRICARE Ambulatory Surgery Center (ASC), make sure that ICD-10 surgical procedure codes have a corresponding CPT® code and a charge for each CPT® code billed.

Certain surgical procedures normally reimbursed at a hospital-based surgery center can also be reimbursed at a freestanding ASC. TRICARE network providers must contact Humana Military to obtain prior authorization for appropriate procedures performed at an ASC. Refer to the TRICARE Policy Manual, Chapter 11 for more information.

Hospital clinic billing: When billing for provider outpatient services in a hospital setting, the following guidelines must be followed. This allows the claim to process in a timely manner and keeps the TRICARE beneficiary from being charged a double copay.

- **Hospital**: Bill revenue code 510 on a UB-04 institutional claim form.
- **Provider**: Bill place of service 19 or 22 on a 1500 claim form. Do not use place of service 11 or the beneficiary will receive a separate copay from the hospital.

Change in hospital classification: TRICARE-authorized hospital providers must immediately inform Humana Military of any change in CMS hospital classification. Notification by the hospital must occur if the provider changes from a short term acute care hospital classification, critical access hospital classification or sole community hospital classification to any other of the three noted classifications. This notification allows Humana Military to properly reimburse hospitals for TRICARE-covered services.

When notifying Humana Military, providers should include the official letter from CMS, the hospital’s point of contact information and the effective date of the CMS hospital classification change. Providers may mail this required information to Humana Military:

TRICARE East Region
ATTN: Correspondence
P.O. Box 8923
Madison, WI 53707-8923
Proper treatment and observation room billing

**Revenue Code 076X:** Determining when to use revenue code 076X (treatment) to indicate use of a treatment room can be complicated and improper coding can lead to inappropriate billing.

Under OPPS, 076X revenue codes are reimbursed based on the HCPCS codes submitted on the claim.

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

- Outpatient surgery procedure code
- Interventional radiology services related to imaging, supervision, interpretation and the related injection or introduction procedure
- Debridement performed in an outpatient hospital department

Revenue Code 0762 (observation room) is the only revenue code that should be used for observation billing. Non-OPPS outpatient observation stays may be reimbursed for a maximum of 48 hours.

Global maternity claims

Global maternity involves the billing process for maternity-related beneficiary claims. After confirming that a patient is pregnant, all charges related to the pregnancy are grouped under one global maternity diagnosis code as the primary diagnosis.

When TRICARE Prime (TRICARE Prime, TPR, TYA Prime) beneficiaries are referred for specialty obstetric care, the primary care manager (PCM) submits a service request notification to Humana Military. Professional and technical components of medically necessary fetal ultrasounds are covered outside of the maternity global fee. The medically necessary indications include, but are not limited to, clinical circumstances that require obstetric ultrasounds to estimate gestational age, evaluate fetal growth, conduct a biophysical evaluation for fetal well-being, evaluate a suspected ectopic pregnancy, define the cause of vaginal bleeding, diagnose or evaluate multiple gestations, confirm cardiac activity, evaluate maternal pelvic masses or uterine abnormalities, evaluate suspected hydatidiform mole and evaluate fetus condition in late registrants for prenatal care.

Maternal serum alpha fetoprotein and multiple marker screen test are cost-shared separately (outside of the global fee) as part of the maternity care benefit to predict fetal developmental abnormalities or genetic defects.

A second phenylketonuria test for infants is allowed if administered one to two weeks after discharge from the hospital as recommended by the American Academy of Pediatrics.

Claims for mutually exclusive procedures

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

Physician-administered drug and vaccine claim filing

The National Drug Code (NDC) number, drug quantity and package unit indicators are necessary on drug and vaccine claim filings when no nationally established TRICARE allowable charge pricing has been set. Visit TRICARE.mil to determine if a TRICARE allowable charge exists for specific drugs or vaccines.

TRICARE Overseas Program (TOP)

Wisconsin Physicians Service (WPS) is the claims processor for the TRICARE Overseas Program (TOP), TOP-Prime and TOP-Prime Remote. TOP Prime/ TOP Prime Remote enrollees require authorization for non-emergency care in the United States.

Overseas claims for National Guard and Reserve members on orders of 30 days or less should be sent to WPS. To expedite claims, the provider should submit a copy of the member’s orders with the claim. The orders verify the member’s eligibility for TRICARE benefits.
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 after processing.

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

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

Claims for NATO beneficiaries

TRICARE covers North Atlantic Treaty Organization (NATO) foreign nations’ armed forces members who are stationed in the United States or are in the United States at the invitation of the U.S. government. They receive the same benefits as American ADSMs, including no out-of-pocket expenses for care if the care is directed by the military hospitals and clinics.

Eligible accompanying family members of ADSMs of NATO nations who are stationed in, or passing through, the United States in connection with their official duties can receive outpatient services under TRICARE Select. A copy of the family member’s identification card will have a foreign identification number or a Social Security Number (SSN) and indicate outpatient services only.

NATO family members do not need military hospital or clinic referrals prior to receiving outpatient services from civilian providers, follow the same prior authorization requirements as TRICARE Select beneficiaries and are responsible for TRICARE Select cost-shares and deductibles.

To collect charges for services not covered by TRICARE, providers must have the NATO beneficiary agree, in advance and in writing, to accept financial responsibility for any noncovered service by signing the TRICARE Noncovered Services Waiver form. To download the form, search for “TRICARE noncovered services waiver” at HumanaMilitary.com

TRICARE does not cover inpatient services for NATO beneficiaries. To be reimbursed for inpatient services, the NATO beneficiary must make the appropriate arrangements with the NATO nation embassy or consulate in advance. NATO beneficiary eligibility is maintained in the Defense Enrollment Eligibility Reporting System (DEERS). Claims submission procedures are the same as for American ADFMs.
Claims for the Continued Health Care Benefit Program (CHCBP)

TRICARE East Region claims
P.O. Box 8923
Madison, WI 53707-8923

Claims for Extended Care Health Option (ECHO)

All claims for ECHO and the DoD Enhanced Access to Comprehensive Autism Care Demonstration must have a valid written authorization and the beneficiary must show as enrolled in ECHO in DEERS.

All claims for ECHO-authorized care (including ECHO Home Health Care and the DoD Comprehensive Autism Care Demonstration) that have been authorized under ECHO must be billed on individual line items. Unauthorized ECHO care claims will be denied.

ECHO claims will be reimbursed for the amount negotiated, the Calendar Year (CY) benefit limit or the TRICARE allowable charge, whichever is lower. Each line item on an ECHO claim must correspond to a line item on the service authorization, or the claim may be denied or delayed due to research and reconciliation.

The billed amount for procedures must reflect the service, not the applicable ECHO benefit limits. Pricing of ECHO services and items is determined in accordance with the TRICARE Reimbursement Manual. Refer to the TRICARE Policy Manual, Chapter 9, Sections 4.1, 11.1, 14.1 and 18.1 at manuals.TRICARE.osd.mil

Claims for TRICARE Reserve Select and TRICARE Retired Reserve

All individuals covered under TRICARE Reserve Select (TRS) should follow the applicable cost-shares, deductibles and catastrophic caps for ADFMS covered under TRICARE Select.

All individuals covered under TRICARE Retired Reserve (TRR) should follow the applicable cost-shares, deductibles and catastrophic caps for retirees and eligible family members covered under TRICARE Select.
TRICARE network providers

File claims with WPS electronically on behalf of TRS and TRR beneficiaries in the same manner as filing other TRICARE claims.

The cost-share for all TRS beneficiaries, including National Guard and Reserve members, is 15 percent of the negotiated fee for covered services from TRICARE network providers. TRICARE will reimburse providers the remaining amount of the negotiated fee.

The cost-share for all TRR beneficiaries, including National Guard and Reserve members, is 20 percent of the negotiated fee for covered services from TRICARE network providers. TRICARE will reimburse providers the remaining amount of the negotiated fee.

Non-network TRICARE-authorized providers

Participation with TRICARE (e.g., accepting assignment, filing claims and accepting the TRICARE allowable charge as payment in full) is encouraged. Non-network providers should submit their TRICARE claims electronically.

The cost-share for all TRS beneficiaries is 20 percent of the TRICARE allowable charge for covered services from participating non-network TRICARE-authorized providers. TRICARE will reimburse the remaining amount of the TRICARE allowable charge.

The cost-share for all TRR beneficiaries is 25 percent of the TRICARE allowable charge for covered services from participating non-network TRICARE-authorized providers. TRICARE will reimburse the remaining amount of the TRICARE allowable charge.

If a non-network provider does not 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.

Visit health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/CMAC-Rates to find the fee schedules.

Supplemental Health Care Program (SHCP) claims

WPS processes and pays claims for SHCP. Send all paper TRICARE claims to:

TRICARE East Region claims
P.O. Box 8923
Madison, WI 53707-8923

The same balance-billing limitations applicable to TRICARE apply to SHCP. For more information, see balance-billing in the important provider information section.

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 (OHI)

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
- Advanced life support air ambulance in conjunction with stem cell transplantation
- Applied Behavior Analysis (ABA)
- Extended Care Health Option (ECHO) services
- Home health services, including home infusion
- Hospice
- Laboratory Developed Tests (LDTs)
- Transplants (solid organ and stem cell, not corneal transplant
- Comprehensive Autism Care Demonstration (CACD)
- Electroconvulsive Therapy (ECT)
- Non-emergency admissions, to include detoxification and rehabilitation services
- Psychoanalysis
- Residential Treatment Centers (RTCs)
- Transcranial Magnetic Stimulation (TMS)

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.

Medically Unlikely Edit (MUE) vs Day Units Time (DUTs) and date spans

MUE indicates that it is unlikely that more than X number of an item would be used in a day. This causes confusion as so many items are ordered on a 30-day or even a 90-day basis. DHA has a list of MUEs at TRICARE.mil.

It is important to note that not all codes have a DHA determined MUE. Supplies should be filed using the date of service, not a date span, and should indicate the DUTs (Code A7033 billed with 90 DUTs).

Providers need to verify all information on TRICARE.mil before sending to claims processing. This field represents the number of units of an item you are submitting. For example, in the observation world 1 unit = 1 hour.

**Note:** Do not file claims with future dates.

Not all service units represent the same measure. Please be sure you know what, if any, units are associated with the code you are submitting on a claim.

There are specific supplies that are distributed in a measure greater than a daily supply. These items are date spanned. There are very few of these and you should check before submitting a date-spanned claim (Example: Date span 01/01/14-01/31/14 for code B4035, and 31 as the DUT).

DME reimbursement/claims tips and guidelines

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule: TRICARE uses the reimbursement rates established by the Centers for Medicare and Medicaid Services (CMS) or the CMAC state prevailing price for DMEPOS items.

CMS updates these rates quarterly during the year. Inclusion or exclusion of a reimbursement rate does not imply TRICARE coverage.

**DME**

Please mail requests to:
TRICARE East Region claims
ATTN: Correspondence/ Corrected claims
P.O. Box 8923
Madison, WI 53707-8923

If you submit on paper, you may include the supporting documentation with the claim; however, there is no guarantee the documentation will be kept with the claim once it arrives in the mailroom at WPS.
Claims denied/rejected due to exceeding MUE/DUT limitations

Requests for reconsideration are an option for providers when services or supplies are denied or rejected due to units or services exceeding the daily limit. Reconsideration will not be considered for luxury or upgraded DME items. Reconsiderations must include documentation that supports the units billed, with as much clinical support as possible. Please follow the “reconsideration process” instructions. The coversheet and tips for filing a reconsideration are also available under the provider forms section on Humana Military’s website. Please do not confuse this with the initial claim filing and supporting documentation. This is a reconsideration process after claims have been denied.

Billing guidelines regarding upgraded DME

Effective 03/03/2013, TRICARE allows the GA and GK modifiers for DME claims processing. This change allows for the recognition, but not payment of, upgraded DME items, except under certain circumstances. Providers are to bill codes with the GA and GK modifiers to indicate which service is the actual equipment ordered and the upgraded equipment ordered.

- **GA**: This is the modifier to indicate the upgraded equipment
- **GK**: This is the modifier to indicate the actual equipment

If the patient is not an ADSM, there must be both a ‘GA’ and a ‘GK’ modifier on the claim to indicate which service is the actual equipment and which service is the upgraded equipment. Providers will only be paid for the actual equipment.

**Note**: This change in policy affects all DME including eyeglasses and hearing aids.

If only one modifier is present the line will deny as needing both modifiers. If both modifiers are present then we will issue payment on the line with the GK modifier as we normally do, and reject the line with the GA modifier indicating it is not medically necessary. This information will also be seen on the EOB and remit.

If the patient is an ADSM and there is an authorization, the claim will process, even if the GA modifier is present. Costs for repairs for upgraded items that TRICARE did not purchase are also the responsibility of the patient.

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 WPS
- Request an adjustment on an allowable charge review from WPS

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.
TRICARE’s Debt Collection Assistance Officer (DCAO) program

DCAOs are located at TRICARE Regional Offices and military hospitals or clinics to assist TRICARE beneficiaries in determining the validity of collection agent claims and/or negative credit reports received for debts incurred as a result of receiving healthcare under the TRICARE program (“healthcare” includes medical and adjunctive dental care under TRICARE).

DCAOs cannot provide beneficiaries with legal advice or fix their credit ratings, but DCAOs can help beneficiaries through the debt-collection process by providing documentation for the collection or credit reporting agency in explaining the debt-inducing circumstances. The DCAO directory is available online at TRICARE.mil/BCACDCAO

Beneficiaries must take or submit documentation associated with a collection action or adverse credit rating to the DCAO (e.g., debt collection letters, TRICARE EOBs and healthcare bills from providers). The more information the beneficiary provides, the less time it will take to determine the cause of the problem.

The DCAO will research the beneficiary’s claim with the appropriate claims processor or other agency points of contact and provide the beneficiary with a written resolution to the collection problem. The DCAO will notify the collection agency that action is being taken to resolve the issue.

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
- Third-party liability 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 new information
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.

An appropriate appealing party must request appeals. 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.

**Appeals and administrative reviews of claims denials**

The following are considered appealable issues:

- Claims denided 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 East Region
Appeals Department
P.O. Box 740044
Louisville, KY 40201-7444

TRICARE CLAIMS INFORMATION
**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.

Defense Health Agency (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 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 (CPTR) 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.
TRICARE electronic claims filing

Electronic claims submission and claims filing information are available at HumanaMilitary.com

Electronic claims filing responsibilities

- Network providers should file TRICARE claims electronically within 90 days of the date care was provided
- Non-network providers are encouraged to take advantage of one of the electronic claims submission options

TRICARE claims auditing

The TRICARE East Region uses a claims auditing tool to review claims on a prepayment basis. This auditing tool is an automated clinical tool that contains specific auditing logic designed to evaluate provider billing for CPT coding appropriateness and to eliminate overpayment on professional and outpatient hospital service claims. Humana Military updates the claims auditing tool periodically with new coding based on current industry standards.

Edits

Follow CPT coding guidelines to prevent claims auditing editing from resulting in claim denials. Claims auditing edits will be explained by a message code on the remittance advice.

The auditing tool also includes, but is not limited to, the following edit categories*:

- Age conflicts
- Alternate code replacements
- Assistant surgeon requirements
- Cosmetic procedures
- Duplicate and bilateral procedures
- Duplicate services
- Gender conflicts
- Incidental procedures
- Modifier auditing
- Mutually exclusive procedures
- Preoperative and postoperative auditing billed
- Procedure unbundling
- Unlisted procedures

*The complete set of code edits is proprietary and, as such, cannot be released to the public.

Review of provider claims

Humana Military checks claims for consistency and new visit frequency through the codes specified. To avoid unnecessary claim line rejections, assign a diagnosis code that represents the reason the procedure is performed, as well as any diagnoses that will impact treatment.

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 documentation substantiating 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 reconsideration. For questions regarding this auditing function, contact Humana Military at 1-800-444-5445.

Send supporting medical record information to:

TRICARE East Region claims
ATTN: Correspondence/ Corrected claims
P.O. Box 8923
Madison, WI 53707-8923

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

Identify OHI in the claim form

- Mark “yes” in box 11d (CMS-1500) or FL 34 (UB-04)
- Indicate the primary payer in box 9 (CMS-1500) or FL 50 (UB-04)
- Indicate the amount paid by the other carrier in box 29 (CMS 1500) or FL 54 (UB-04)
- Indicate insured’s name in box 4 (CMS-1500) or FL 58 (UB-04)
- Indicate the allowed amount of the OHI in FL 39 (UB-04) using value code 44 and entering the dollar amount
Payment guidelines

If TRICARE is the secondary payer, submit the claim to the primary payer first. If the claim processor’s records indicate that the beneficiary has one or more primary insurance policies, submit EOB information from 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. 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 East Region claims
P.O. Box 8923
Madison, WI 53707-8923
Reimbursement rates and methodologies are subject to change per Department of Defense (DoD) guidelines. For more information, refer to the TRICARE Reimbursement Manual at manuals.TRICARE.osd.mil

**Reimbursement limitations**

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 health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/CMAC-Rates to find the TRICARE allowable charges.

The TRICARE allowable charge is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. For non-network providers, TRICARE will reimburse the lesser of the TRICARE allowable charge or the provider’s billed charge for the service.

For example:

- If the TRICARE allowable charge for a service from a non-network provider is $90 and the billed charge is $50, TRICARE will allow $50 (the lower of the two charges)
- If the TRICARE allowable charge for a service from a non-network provider is $90 and the billed charge is $100, TRICARE will allow $90 (the lower of the two charges)

In the case of inpatient hospital services from a non-network provider, the specific hospital reimbursement method applies. For example, the Diagnosis-Related Group (DRG) rate is the TRICARE allowable charge for inpatient hospital services.

In the case of outpatient hospital claims subject to the TRICARE Outpatient Prospective Payment System (OPPS), services will be subject to OPPS Ambulatory Payment Classifications (APCs) where applicable.

Non-network nonparticipating providers have the legal right to charge beneficiaries up to 115 percent of the TRICARE allowable charge for services.

**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 non-specialty basis

For the latest details concerning prevailing rates, see the TRICARE Reimbursement Manual, Chapter 5, Section 3.7.2.4.2 at manuals.TRICARE.osd.mil

**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 an anesthesiologist provides a portion of the anesthesia service and a nonphysician anesthetist performs the remainder, the claim must identify exactly which services each type of provider provided. 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:
• \((\text{time units} + \text{RVUs}) \times \text{conversion factor}\)

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

A base unit includes reimbursement for:
• Preoperative examination of the beneficiary
• Administration of fluids and/or blood products incident to the anesthesia care
• Interpretation of 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 trans-esophageal echocardiography. When multiple surgeries are performed, only the RVUs for the primary surgical procedure are considered, while the time units should include the entire surgical session.

**Note:** This does not apply to continuous epidural analgesia.

**Time unit:** Time units are measured in 15-minute increments, and any fraction of a unit is considered a whole unit. Anesthesia time starts when the anesthesiologist begins to prepare the beneficiary for anesthesia care in the operating room or in an equivalent area. It ends when the anesthesiologist is no longer in personal attendance and the beneficiary may be safely placed under post-anesthesia supervision. 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 nonphysician 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
**Present-On-Admission (POA) 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 [health.mil/DRG](http://health.mil/DRG)

Any claim that does not report a valid POA indicator for each diagnosis on the claim will be denied.

**POA code descriptions**

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

<table>
<thead>
<tr>
<th>POA code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Indicates that the condition was present on admission.</td>
</tr>
<tr>
<td>W</td>
<td>Affirms that the provider has determined, based on data and clinical judgment, that it is not possible to document when the onset of the condition occurred.</td>
</tr>
<tr>
<td>N</td>
<td>Indicates that the condition was not present on admission.</td>
</tr>
<tr>
<td>U</td>
<td>Indicates that the documentation is insufficient to determine whether the condition was present at the time of admission.</td>
</tr>
<tr>
<td>1</td>
<td>Prior to Fiscal Year (FY) 2011, signified exemption from POA reporting. The Centers for Medicare &amp; 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.)</td>
</tr>
</tbody>
</table>

Figure 8.1
Diagnosis-Related Group calculator

The DRG calculator is available at health.mil/DRG

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 POA 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 WPS, 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 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 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 WPS 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 Profession Shortage Areas (HPSAs)

Network and non-network physicians (MDs, DOs, podiatrists, oral surgeons and optometrists) who qualify for Medicare bonus payments in HPSAs may be eligible for a 10 percent bonus payment for claims submitted to TRICARE. Behavioral healthcare providers who are eligible for HPSA bonuses are MDs and DOs. Nonphysicians (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, WPS 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 Select, 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 healthcare.

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.

For information about home health agency pricing, refer to the TRICARE Reimbursement Manual, Chapter 1, Section 33 at manuals.TRICARE.osd.mil

**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 Critical Access Hospital (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 SCH Policy can be found in TRICARE Reimbursement Manual, Chapter 14, Section 1 located at manuals.TRICARE.osd.mil

**Tips for filing a request for anticipated payment**

When filing a Request for Anticipated Payment (RAP), keep in mind the following:
- The bill type in Form Locator (FL) 4 of the UB-04 is always 322 or 332
- The “to date” and the “from date” in FL 6 must be the same and must match the date in FL 45
- FL 39 must contain code 61 and the core-based statistical area code of the beneficiary’s residence address
- There must be only one line on the RAP, and it must contain revenue code 023 and 0 dollars. On this line, FL 44 must contain the Health Insurance PPS code
- The quantity in FL 46 must be 0 or 1
- FL 63 must contain the treatment authorization code assigned by the outcome assessment information set

**Note:** This is not Humana Military’s prior authorization number.
Tips for a final claim

• Network home healthcare providers must submit TRICARE claims electronically. The bill type in FL 4 must always be 329 or 339.
• In addition to the blocks noted for the Request for Anticipated Payment (RAP) above, each actual service performed with the appropriate revenue code must be listed on the claim form lines.
• The claim must contain a minimum of five lines to be processed as a final RAP.
• The dates in FL 6 must be a range from the first day of the episode plus 59 days.
• Dates on all of the lines must fall between the dates in FL 6.

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

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 non-coverage. Use the following modifiers to identify repair and 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/Providers/WhatTRICAREPays

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.

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 TRICARE Non-covered Service Waiver form on file in order to bill the beneficiary for the cost above the approved DME item.
Assistant surgeon services

TRICARE policy defines an assistant surgeon as any physician, dentist, podiatrist, certified Physician Assistant (PA), Nurse Practitioner (NP) or Certified Nurse Midwife (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 is 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 76 – TRICARE Provider Handbook
- 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, WPS 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 behavioral 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/Providers/WhatTRICAREPays

Filing claims for Partial Hospitalization Program (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 payments are those furnished by clinical social workers, occupational therapists and alcohol and addiction counselors.

The claim must include a behavioral 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 will not be included in the cap amount calculations.

Temporary Transitional Payment Adjustments (TTPAs)

TTPAs are in place for all hospitals, both network and non-network, to buffer the initial decline in payments upon implementation of TRICARE OPPS. For network hospitals, the TTPAs cover a four-year period.

The four-year transition sets higher payment percentages for the 10 APC codes for Emergency Room (ER) and hospital clinic visits (APC codes 604 to 609 and 613 to 616), with reductions in each transition year. For non-network hospitals, the TTPAs cover a three-year period, with reductions in each transition year.

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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 healthcare-related problems and assist beneficiaries in obtaining medical care through TRICARE. BCACs were previously known as Health Benefits Advisors (HBAs).

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 healthcare program established to provide purchased healthcare 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 Select.

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 healthcare outcomes by providing education to beneficiaries through nonphysician 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 healthcare 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 healthcare 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 healthcare 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 healthcare services from other than their PCMs or without a referral from their PCMs), all requirements applicable to TRICARE Select 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-behavioral healthcare 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 healthcare 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.

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