Humana
Military

TRICARE®

TRICARE provider handbook

East Region 2025

U.S. Navy photo by Deidre Smith, Naval Hospital Jacksonville

Table of contents

1. Welcome to TRICARE and the East Region 7

What is TRICARE? 7
TRICARE regions 7
Your regional contractor 8
Humana Military claims subcontractor 8
TRICARE policy resources and manuals 8
Healthcare Effectiveness Data and Information Set (HEDIS) performance measures 8
Health Insurance Portability and Accountability Act of 1996 (HIPAA) 9
Military Health System (MHS) Notice of Privacy Practices and other information sources 9

2. Getting started 10

What is a TRICARE provider? 10
TRICARE authorizations and certification 11
TRICARE credentialing 11
Provider self-service 12
Humana Military Interactive Voice Response (IVR) 15
Provider education and locator at HumanaMilitary.com 15

3. Important provider information 16

Military hospital or clinic (MTF) 16
Primary Care Managers (PCM) 16
Corporate Services Provider (CSP) class 17
Right to appeal 17
Provider responsibilities 17
Missed appointments 17
Nondiscrimination policy 17
Office and appointment access standards 18
Specialty care responsibilities 18
Clear and Legible Reports (CLR) 19
Moonlighting providers 19
Health Information Exchange (HIE) 20
Centers for Medicare and Medicaid Services (CMS) Meaningful Use 20
Veterans Affairs (VA) healthcare facilities 20
VA and Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) 20
Beneficiary rights and responsibilities 20

4. TRICARE eligibility 21

Eligibility for TRICARE and VA benefits 21
Verifying benefit coverage 21
Verifying eligibility 21
Common Access Card (CAC) 21
Veterans Affairs benefits as Other Health Insurance (OHI) 22

Table of contents

5. TRICARE program options 23

TRICARE Prime coverage options. 23
TRICARE Prime 23
TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) 23
TRICARE Prime Point-Of-Service (POS) option 24
TRICARE Select 24
Supplemental Health Care Program (SHCP). 24
Warrior Navigation and Assistance Program (WNAP) 25
TRICARE For Life (TFL) 25
How TFL works 26
TRICARE for the National Guard and Reserve 26
TRICARE Reserve Select (TRS) 26
TRICARE Retired Reserve (TRR) 27
Line-Of-Duty (LOD) care for National Guard and Reserve members 27
Coverage when activated more than 30 consecutive days. 28
TRICARE Young Adult (TYA) 28
TRICARE Overseas Program (TOP) 28
TRICARE Extended Care Health Options (ECHO) 28
ECHO provider responsibilities 29
ECHO benefits. 29
ECHO costs 29
Autism Care Demonstration (ACD). 29
Transitional healthcare benefits 30
TRICARE Pharmacy Program 31
Generic drug use policy 32
Quantity limits 32
TRICARE Pharmacy prior authorizations or medical necessities. 33
Step therapy. 33
Pharmacy benefits for Medicare-eligible beneficiaries 34
Specialty medication. 34
Limitations and exclusions 35
TRICARE dental options 35
US Family Health Plan (USFHP) information 36
USFHP list of providers 36

6. Referrals and authorizations 37

TRICARE referrals and prior authorizations 37
Referral and authorization submission options 37
Tips for making referrals and authorizations 37
Tips for hospital admission notifications 38
Specialist-to-specialist referrals for the same episode of care. 38
Prior authorization requirements in the East Region 38
Military hospitals and clinics and ROFRs 39
Autofax confirmation 40

Table of contents

7. **Medical coverage** **41**

TRICARE-covered benefits and services 41
Emergency care. 41
Urgent care 41
Maternity care. 41
Home healthcare 42
Telemedicine 43
Infusion therapy 45
Hospitalization 45
Skilled Nursing Facility (SNF) care 45
Hospice care. 45
Laboratory, X-ray and Laboratory Developed Test (LDT) services 45
Durable Medical Equipment (DME) 46
Upgraded DME (deluxe, luxury and immaterial features). . . . 46
Referral and authorization guidelines for DME 46
DMEPOS rental vs purchase 47

8. **Behavioral healthcare.** **47**

Covered services information 47
Non-covered conditions and treatment. 48
Obtaining referrals and prior authorizations 49
Referral and authorization requirements 49

9. **Healthcare management**. **50**

Concurrent review 50
Retrospective review 50
Discharge planning. 50
Case management 50
Clinical quality management 51
TRICARE Quality Monitoring Contractor (TQMC) 51
Medical records documentation 51
Peer Review Organization (PRO) agreement 51
Appealing a decision. 52

10. **Claims and billing information** **53**

Claims processing standards 53
TRICARE claims filing responsibilities 53
HIPAA transaction standards and code sets 53
Signature on file requirements 53
TRICARE electronic claims filing 54
Electronic Funds Transfer (EFT) 54
Find the correct address for new, corrected or revised claims and recoupments or refund 53
Balance-billing 54
TRICARE and TPL insuranceTRICARE and TPL insurance 54
Noncovered services 55

Hold-harmless policy. 55
Processing claims for out-of-region care 55
Duplicate claims 56
Proper billing for multiple procedures 56
An Important Message from TRICARE form 56
Hospital and facility billing 56
Proper treatment and observation room billing 57
Global maternity claims 57
Claims for mutually exclusive procedures 58
Physician-administered drug and vaccine claim filing 58
TRICARE and OHI 58
OHI: Services requiring TRICARE prior authorization 58
Identify OHI in the claims form 59
TRICARE and workers' compensation 59
Claims by TRICARE program 59
TRICARE network providers 61
Non-network TRICARE-authorized providers 61
Durable Medical Equipment (DME) claims 61
DME reimbursement/claims tips and guidelines 61
Medically Unlikely Edit (MUE) vs Day Units Time (DUT) and date spans 62
Claims denied/rejected due to exceeding MUE/DUT limitations 62
Billing guidelines regarding upgraded DME 62

11. Other claims and billing information. 63

Avoiding collection activities 63
TRICARE's Debt Collection Assistance Officer (DCAO) program 63
Review of provider claims 63
Section 1869/1878 Social Security Act: Appeals determination 63
Fraud and abuse 64
Claims adjustments and allowable charge reviews 65
Appeals of claims denials 65
TRICARE claims auditing 67
Edits 67
Claims reconsiderations 67
Payment guidelines 68
Payer ID to electronic claims 68

12. Reimbursement methodologies 69

Anesthesia claims and reimbursement 69
Anesthesia procedure pricing calculator 69
Ambulance Fee Schedule (AFS) for TRICARE 69
Ambulatory Surgery Center (ASC) charges 69
Ambulatory Surgery Reimbursement 69
Assistant surgeon services 69
Bonus payments calculations 70

Table of contents

Search

Bonus payments in Health Profession Shortage Areas (HPSA) . . . 70
Calculating anesthesia reimbursement rates . . . 70
Capital and direct medical education cost reimbursement . . . 71
Diagnosis-Related Group (DRG) calculator . . . 72
Diagnosis-Related Group (DRG) reimbursement . . . 72
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) pricing . . . 72
Filing claims for Partial Hospitalization Program (PHP) charges . . . 73
Home Health Agency (HHA) pricing . . . 73
Home infusion drug pricing . . . 73
Hospice pricing . . . 73
Modifiers . . . 74
Outpatient Prospective Payment System (OPPS) . . . 74
Present-On-Admission (POA) code descriptions . . . 75
POA indicator . . . 75
Reimbursement limitations . . . 75
Skilled Nursing Facility (SNF) pricing . . . 76
Sole Community Hospitals (SCH) . . . 76
State-prevailing rates . . . 76
Surgeon’s services for multiple surgeries . . . 76
Tips for a final claim . . . 77
Tips for filing a Request for Anticipated Payment (RAP) . . . 77

13. Provider tools and resources . . . 78

Check eligibility . . . 78
Claims information . . . 78
Education presentations . . . 78
Find a provider . . . 78
Forms . . . 78
Provider self-service . . . 78
Self-guided provider orientation . . . 78
Webinars . . . 78
Acronyms . . . 79
Glossary of terms . . . 81
Index . . . 84

Search

Welcome to TRICARE and the East Region

What is TRICARE?

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

TRICARE-eligible beneficiaries may include Active Duty Service Members (ADSM) 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 US 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.

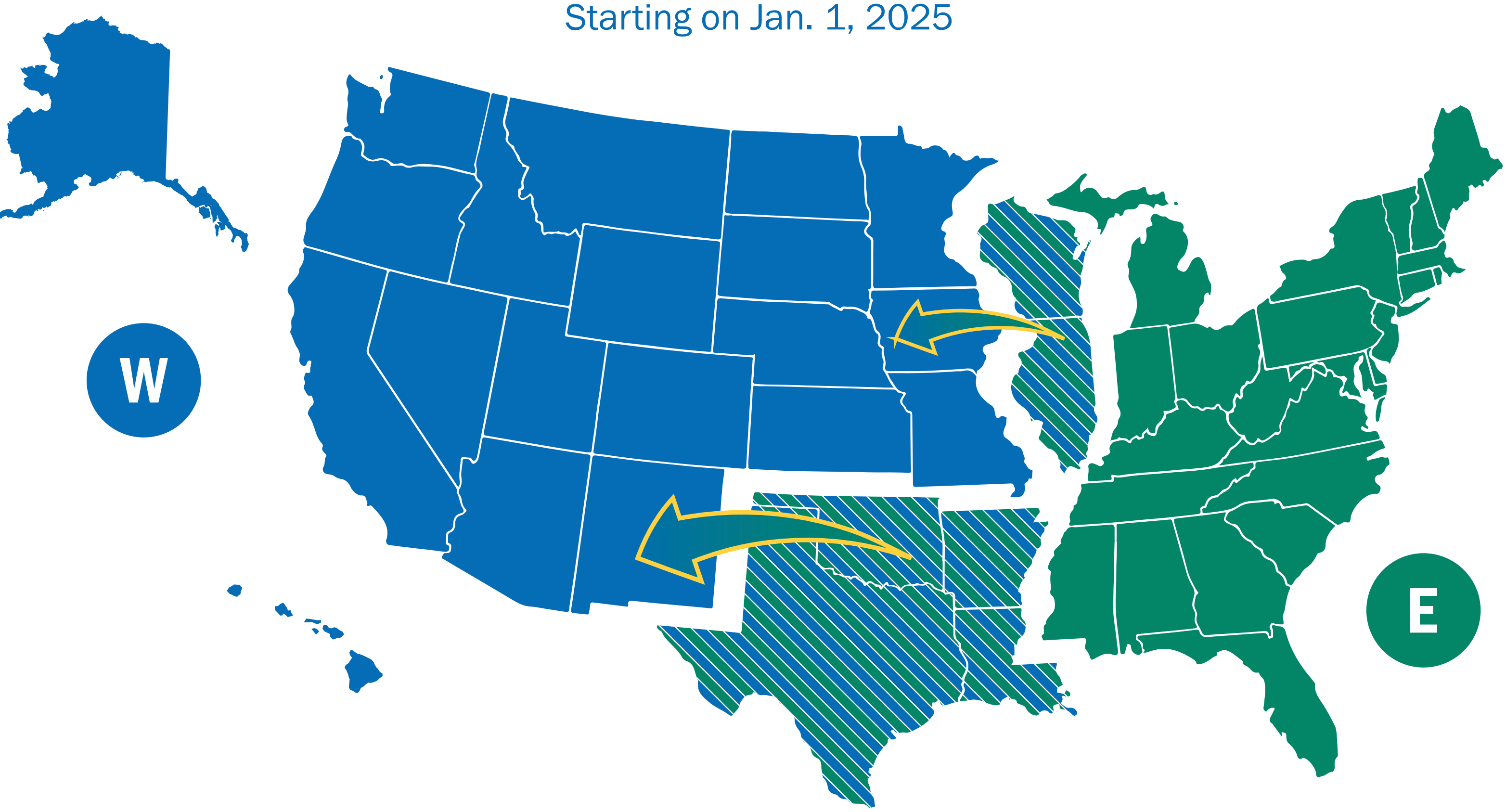
TRICARE regions

East Region
Humana Military
(800) 444-5445
HumanaMilitary.com

West Region
TriWest Healthcare Alliance
888-TRIWEST (874-9378)
tricare.triwest.com

TRICARE Stateside Regions

Starting on Jan. 1, 2025



Welcome to TRICARE and the East Region

Your regional contractor

A TRICARE contractor since 1995, Humana Military manages the East Region. In partnership with the Department of Defense, Humana Military 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, Connecticut, Delaware, Florida, Georgia, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri (Eaker AFB BRAC and St. Louis area only); New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia and West Virginia.

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 US combat readiness.

Humana Military claims subcontractor

PGBA, LLC (PGBA) is the Humana Military partner for claims processing in the TRICARE East Region.

US Marine Corps photo by Sgt. Colton K. Garrett

TRICARE policy resources and manuals

The Defense Health Agency (DHA) provides Humana Military with guidance (as issued by the Department of Defense (DoD)) for administering TRICARE-related laws. The DoD issues this direction through modifications to the Code of Federal Regulations (CFR) 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 (TPM)*, *TRICARE Operations Manual (TOM)* and *TRICARE Reimbursement Manual (TRM)*. Refer to HumanaMilitary.com/News for current information about policy changes, timelines and implementation guidance.

View TRICARE manuals and policies

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.

Welcome to TRICARE and the East Region

Improving HEDIS scores is another element of Humana Military's ongoing efforts to help TRICARE beneficiaries improve their health and better manage chronic health conditions. This goal also supports the population health segment of the Defense Health Agency's (DHA) quadruple aim.

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 includes beneficiary-identifiable health details, such as individually identifiable health information.

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 MHS, one of the most important exceptions to the authorization requirement is the military command exception. This permits limited disclosures of PHI about 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 US Department of Veterans Affairs (VA).

Learn more about the HIPAA Privacy Rule

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.

Learn more about responding to privacy breaches

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.

Download the MHS Notice of Privacy Practices

These notices serve as beneficiary advocates for privacy issues and respond to beneficiary inquiries about PHI and privacy rights. Learn more about other HIPAA requirements.

See more about Health Information Privacy

Learn more about the Military Health System (MHS) Military Command Exception's requirements

Getting started

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

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, pharmacies, etc. 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
- Non-network

Network providers[1]

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

Non-network providers[2]

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
- 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

Non-participating 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 webpage.)

Getting started

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.

All providers (network and non-network) must be TRICARE certified in accordance with the TRICARE Policy Manual. An authorized provider is any provider who meets the requirements set forth in 32 CFR 199.6 and in the TPM, Chapters 1 and 11. If a beneficiary submits a claim for services provided by a non-participating individual professional provider who is known to be legally practicing and is eligible for TRICARE-authorization, the provider shall be certified and payment shall be made to the beneficiary.

Non-participating non-network providers do not have to accept the TRICARE-allowable charge or file claims for beneficiaries.

Certified marriage and family therapists (network and non-network) must participate on claims since they are required to enter into a participation agreement with TRICARE during the certification process.

All providers must submit certification forms to become a TRICARE-authorized provider. Find online and submit the applicable form below:

- Applied Behavior Analysis (ABA) providers certification applications
- Practitioner certification applications
- Facility/ancillary certification applications
- Telemedicine-only provider certification applications

Providers can use the link below to check the status of their certification application:

- Provider Certification Status Self-service

US Army photo by Army 1st Lt. Stephanie Sweeney

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 professional state license* that is current, valid, unrestricted and not under probation in the state(s) they practice within
- Have a Drug Enforcement Agency (DEA) registration that is current, valid, unrestricted and not under probation, if applicable to their practicing specialty
- Have a state controlled dangerous substance registration that is current, valid, unrestricted and not under probation, 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

*Refer to TRICARE Operations Manual Ch. 11, Sec 3.2

Providers requiring credentialing include:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Dental Medicine (DMD) (must practice oral and maxillofacial surgery)

- Doctors of Dental Surgery (DDS) (must practice oral and maxillofacial surgery)
- Doctors of Podiatric Medicine (DPM)
- Doctors of Optometry (OD)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Psychologists
- Master's level clinical social workers
- Master's level clinical nurse specialists or psychiatric nurse practitioners
- Other behavioral health specialists who are licensed, certified or registered by the state to practice independently

Credentialing is also required for the following institutional providers:

- Acute inpatient facilities
- Free-standing surgical centers
- Home Health Agencies (HHA)
- Skilled Nursing Facilities (SNF)
- Behavioral healthcare facilities providing behavioral health or substance abuse services in the following settings:
  - Inpatient
  - Residential
  - Ambulatory

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

- Have a current signature and date on the facility credentialing application
- Have a state license that is current, valid, unrestricted and not on probation, as applicable
- 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 Inspector General (OIG), the General Services Administration (GSA) or System for Award Management (SAM)
- Have acceptable accreditation status appropriate to the facility

The provider must wait to receive final notification of contract execution and credentialing approval from Humana Military before providing care to TRICARE Prime beneficiaries as a network provider.

Humana Military monitors each network provider's quality of care and adherence to the Department of Defense (DoD), TRICARE and Humana Military policies. Network providers must be re-credentialed at least every three years.

Provider self-service

Provider self-service offers many features that will save time, ensure patient privacy and help manage provider offices 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:

- Verify patient eligibility
- Create and review referrals and authorizations
- Submit claims and check claim status
- Look up codes
- View remittances
- Access pharmacy data by patient
- Access quality and affordability data
- Manage your profile including making demographic updates

Register for self-service now

Discover our guide to provider self-service to learn how to take advantage of this secure tool. Enrolling in self-service requires a nine-digit tax ID or nine-digit EIN.

MAJOR FEATURES INCLUDE:

TRICARE patient profile

- Up to five eligibility checks at a time — in real time
- Cost-share/Copay info
- Program information
- Beneficiary eligibility history
- Other Health Insurance (OHI) information
- Referral by patient status
- Claims by patient status

Getting started

Code lookup

- Access Current Procedural Terminology (CPT), Healthcare Common Procedure Code System (HCPCS) and diagnosis code lookup about covered procedures and services, including:
    - Limitations and exclusions
    - Exempt from Prime referrals
    - Non-covered service

Referrals and authorizations

- Building referral/authorization request
- Updating existing referrals and authorizations
- Adding visits and services to referrals
- Updating admission and discharge dates for inpatient hospital stays
- Extending the coverage period
- Adding procedure codes not already identified
- Accessing code lookup messages about exceptional procedures and diagnoses
- Selecting a provider
- Entering up to five lines of pertinent clinical information to be transmitted to the referred-to provider
- Attaching X-rays, pictures and notes where needed

TRICARE provider profile

- Update requests by locations
- View professional provider credentialing status
- View Primary Care Manager (PCM) panel count and listing to include patient detail on referrals, Healthcare Effectiveness Data and Information Set (HEDIS) alerts and pharmacy
- Search network provider types of service by location
- View professional provider counts and listings by location
- View and update practitioner records

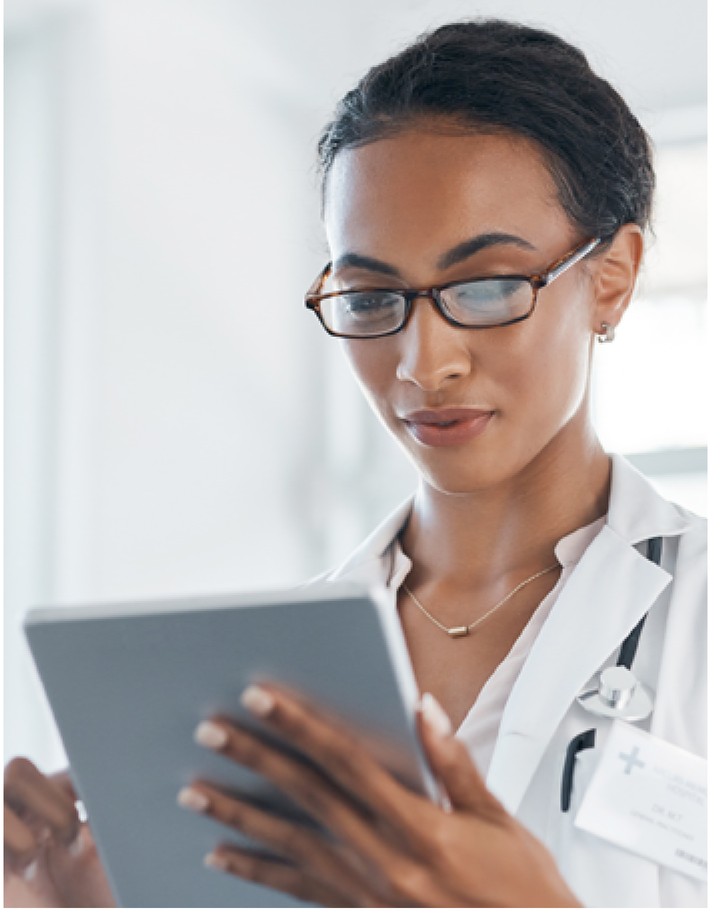
Claims

- Check status of existing claims
- Review line level details
- View and print remittances
- View and print letters
- View notifications
- Submit new claims
- View recoupment information

Gaining access to provider self-service

Providers have four different options to receive access:

- **Manual approval process:** 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 representative will review the request and confirm or deny the right to obtain access.
- **Activation code:** Providers may use an activation code obtained from a Humana Military representative for the provider ID they want to access.
- **Referral fax key code:** 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.
- **Humana Military representative on-site:** Provider representative grants access by entering key information while at the provider's location.



Getting started

Trusted site information

If there is concern about misuse of internet access, designate HumanaMilitary.com and infocenter.humana-military.com/provider/service/Account/Login as trusted sites. A trusted site is a website that is trusted not to damage a computer. If the security level of the Internet Explorer browser is high, access to a specific website may not be allowed. To access the website, add the URL to a trusted sites list or change the security level to medium or lower. When using a high security level, add the web application URLs to the 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
- The security level for this zone box may require action:
    - 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 Windows Vista is running, 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

You can set up **Firefox** to always allow or block specific sites from storing information. You can also allow a site to store only for a single session:

- In the Cookies and Site Data section, click Manage Exceptions
- Type in the exact address of the site you want to allow or block, or select the site if it’s already on the list
- Click Block , Allow for Session or Allow
- Click Save Changes to finish

To add a trusted site in **Google Chrome**, follow these steps:

- Go to Settings then choose Advanced
- Go to Privacy and security then click Content settings
- Go to Cookies; click Allow then Add
- Type the web address: http://support.cloudstore.dell.com then click ADD

For **Edge** browser, follow these steps to add trusted-site information:

- Open the control panel
- Click or double-click the Internet Options icon
- In the Internet Properties window, click the Security tab
- Select Trusted sites and click the Sites button
- Type the address of the trusted website in the Add This Website to Field text box
- Click the Add button and click OK to save the addition to the site

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, (800) 444-5445, which is available 24 hours a day, seven days a week. IVR is an automated phone system technology that allows incoming callers to access information via a voice response system of prerecorded messages without having to speak to an agent, as well as to utilize menu options via touch tone keypad selection or speech recognition to have their call routed to a specific department or specialists.

Eligibility and benefits

- General information such as primary and specialist visit out of pocket amounts
- Deductible and catastrophic cap amounts
- Current plan coverage effective date
- Primary Care Manager (PCM) assignment

Authorizations and Referrals

- CPT code lookup
- Status and approval details
- Hospital admissions and discharge information
- Request a fax form for completion

Claims

- Status and processed details
- Due to the complexity of some denials, not all denial reasons are quoted via the IVR
- Payment information to include check details

FAQs

Humana Military's IVR offers general information on each of the following topics and directs callers to where to find additional information online:

- COVID-19
- Medical records
- Telemedicine
- Flu vaccine
- Continued Healthcare Benefit Program (CHCBP)
- Hours of operation
- Mailing addresses
- Traveling

If looking for TRICARE providers, the IVR will advise on how to find the provider locator and find care tools online.

Provider education and locator at HumanaMilitary.com

Provider education at HumanaMilitary.com supports the TRICARE program and is available to all providers with internet access. Educational options and downloadable items include:

- TRICARE Provider Handbook
- Provider forms
- Provider resources and claims information
- TRICARE provider education PowerPoint® presentations

The locator is the electronic version of a network provider directory. The Utilization Review Advisory Committee (URAC) is the accrediting body for our locator. Business rules for display are defined by URAC's accreditation standards. A comprehensive training library for providers has a calendar of live trainings and offers self-guided webinars and short tutorials on topics like patient eligibility and referrals and authorizations.

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.

Important provider information

Military hospital or clinic (MTF)

A military hospital or clinic is a healthcare facility usually located on a military installation. The civilian TRICARE provider network supplements the resources of these facilities and may work closely with them to ensure patients get the care they need. Some TRICARE beneficiaries will have a Primary Care Manager (PCM) at a military hospital or clinic. Additionally, some military hospitals and clinics participate in the Right of First Refusal (ROFR) process. The ROFR process enables the hospital's or clinic's services by recapturing specialty care for TRICARE Prime beneficiaries that live within access to care standards of the military hospital or clinic.

Locate a military hospital or clinic

Primary Care Managers (PCM)

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.

Learn more about referral and authorization requirements

PCMs can be a part of military healthcare facilities or civilian TRICARE network providers. The following provider specialties may serve as a TRICARE PCM:

- Family practitioner
- General practitioner
- Internal medicine physician
- Nurse practitioner
- Physician assistant
- Pediatrician
- Obstetricians and gynecologist (Gender restrictions apply)

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.

PCM's roles and responsibilities:

- Primary care services are typically, although not exclusively, provided by internal medicine physicians, family practitioners, pediatricians, general practitioners, physician assistants 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.
- PCMs are required to provide access to care 24 hours a day, seven days a week, including after-hours and urgent care services, or arrange for on-call coverage by another provider.

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

- **Routine care:** The PCM or on-call provider instructs the TRICARE Prime beneficiary to contact the PCM's office on the next business day for an appointment.
- **Urgent care:** The PCM or on-call provider coordinates timely care for the TRICARE Prime beneficiary.
- The on-call physician should contact the PCM within 24 hours of an inpatient admission to ensure continuity of care.
- PCMs referring patients for specialty care may need to coordinate the referral with Humana Military.
- Active Duty Service Members (ADSM) must have referrals for all care outside of military hospitals and clinics (except for emergencies or as provided in TRICARE Prime Remote (TPR) regulations, if applicable), including all behavioral healthcare services. If the ADSM has an assigned civilian PCM under TPR, all specialty guidelines must be followed.

Important provider information

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
- Freestanding bone-marrow transplant 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 Diagnostic Testing Facility (IDTF)/ Physiological lab
- Radiation therapy programs

Non-participating providers interested in becoming TRICARE-participating ones can apply to become a TRICARE-authorized provider.

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.

Right to appeal

Humana Military has established minimum credentialing/eligibility criteria for inclusion in the provider network. Failure to meet the minimum credentialing/eligibility criteria established by the credentialing committee is not reportable to any external agency.

To appeal a decision, Humana Military must receive notification of the appeal within 30 calendar days of the provider's notification that minimum credentialing/eligibility was not met. All documentation must be included to support the appeal. The first level review panel will review the appeal and documentation. Notification of outcome will be in writing. Failure to comply within the 30 calendar day period constitutes a waiver of the right to appeal.

Individuals placed on probation or whose license has otherwise been restricted are not considered to be practicing at the full clinical practice level.

Provider responsibilities

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

This handbook is not all-inclusive and provides an overview of TRICARE program rules and regulations and Humana Military policies and procedures.

Missed appointments

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

Nondiscrimination policy

All TRICARE-authorized providers agree not to discriminate against any TRICARE beneficiary on the basis of his or her race, color, national origin or any other basis recognized in applicable laws or regulations. To access the full TRICARE policy, refer to the TRICARE Operations Manual.

US Army photo by: Mark R. W. Orders-Woempner

Important provider information

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 within the Humana Military network 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 who are 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 or reschedule their appointment for another time without penalty.

Specialty care responsibilities

Specialty care may require Primary Care Manager (PCM) referrals or prior authorization from TRICARE East.

TRICARE Prime beneficiaries who live within a 60-minute drive of a military hospital or clinic or who have waived their access to care, may be required to first seek specialty care, ancillary services and physical therapy at the military hospital or clinic based on availability of services provided at the nearest location.

PCM 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 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 services. Although a PCM referral is not required for outpatient office-based behavioral health services (except for ADSM), prior authorization may be required for non office-based and inpatient services. Care rendered without prior authorization will be reviewed retrospectively and may result in a penalty of up to 50 percent. The cost of this penalty will be borne by the provider, and the beneficiary is held-harmless.

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

- **TRICARE Prime:** ADSMs: PCM and/or 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):** ADFMs must obtain PCM referrals for any care they receive from providers other than their PCMs, except for preventive care services from network providers, behavioral health outpatient office-based services, or when using the Point-Of-Service (POS) option. In addition, prior authorization from Humana Military is required for certain services.
- **Retirees and retiree family members:** Retirees and retiree family members enrolled in TRICARE Prime must obtain PCM referrals for any care they receive from providers other than their PCM, with the exception of preventive care services from network providers, behavioral health outpatient office-based services, urgent care rendered in an urgent care center or convenience clinic, 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.

As it applies to each beneficiary type and program option, 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.

Learn more 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 treatment 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.

Clear and Legible Reports (CLR)

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

View Clear and Legible Reports (CLR) FAQs

Moonlighting providers

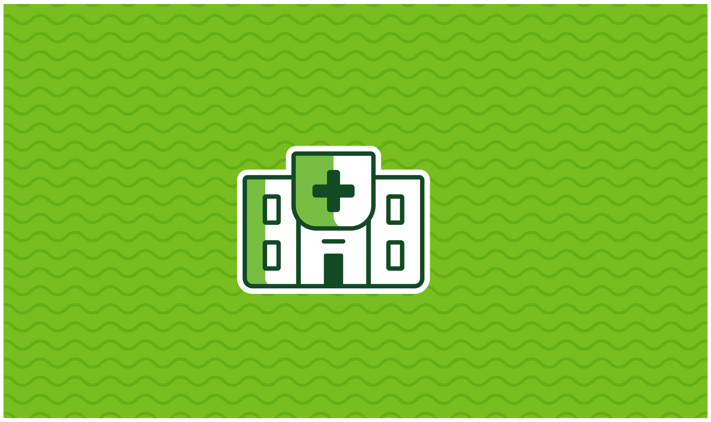
Medical personnel who are part of the uniformed services-active duty, Reserve/Guard on active duty, civil service and government-contracted employees cannot receive dual compensation for services provided to TRICARE beneficiaries. If the medical personnel are actively being compensated through normal 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 (DoD) 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: The Defense Health Agency (DHA) has authorized exceptions on a case-by-case basis for VA 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.

See electronic and paper CMS-1500 and UB-04 claim forms. Billing TRICARE for services or supplies as described will result in denied claims, recoupment and/or possible fraud investigation.



Important provider information

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.

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.

Veterans Affairs (VA) healthcare facilities

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 their VAMC referral information and reimbursement instructions at the time of service. For more information, call (800) 444-5445.

VA and Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)

Through this network agreement, providers understand and agree to being reported to the VA and CHAMPVA as a TRICARE network provider. This agreement will give the VA 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.

Questions regarding CHAMPVA:

Phone: (800) 733-8387
Email: hac.inq@va.gov

Beneficiary rights and responsibilities

TRICARE beneficiaries have rights regarding their healthcare and responsibilities for participating in those healthcare decisions. These rights and obligations are explained in An Important Message from TRICARE.

TRICARE eligibility

Eligibility for TRICARE and VA benefits

Veterans eligible for VA healthcare benefits and TRICARE are considered dual-eligible. Eligibility for healthcare through the VA for a service-connected disability is not considered double coverage. If an individual is eligible for healthcare through both the VA 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 VA. However, TRICARE will not duplicate payments made by or authorized to be made by the VA for treatment of a service-connected disability.

Verifying benefit coverage

Providers should use code lookup on provider self-service. The service or procedure code shows if the service requires a referral or is exempt from referral requirements if it involves a TRICARE Prime beneficiary. Code lookup also identifies non-covered services and procedures or ones that may be on the No Government Pay Procedure Code List.

Find code or service/procedure coverage information on provider self-service or by contacting us.

Verifying eligibility

To verify eligibility, TRICARE beneficiaries should present either a Common Access Card (CAC), military ID card or eligibility letter at the time of service. Check the expiration date before providing care and make a copy of both sides of the ID card for office patient files.

Note: A CAC or ID card alone does not confirm TRICARE eligibility. Most eligibility is based on the Defense Enrollment Eligibility Reporting System (DEERS). Providers can use the sponsor's SSN or Department of Defense (DoD) benefits number (DBN) to verify eligibility using provider self-service.

Verify eligibility now

Common Access Card (CAC)

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

Military identification cards

- Active Duty Service Members (ADSM), family members over age 14, 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 allows users 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 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. Possible ID numbers include:

- **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 nine-digit sponsor SSN or an 11-digit DBN, ask the beneficiary to provide the two numbers.

Please review office systems to ensure that claims submissions contain the appropriately formatted nine-digit SSN or 11-digit DBN. Please call (800) 782-2680 with any questions.

Providers may verify TRICARE Prime or TRICARE Select eligibility in one of the following ways:

- With 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 (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. 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.
- Active Duty Service Members (ADSM) 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 are entitled to premium-free Medicare. ADFMs under the age of 65, who are entitled to premium-free Medicare Part A remain TRICARE eligible to enroll in TRICARE Prime or TRICARE Select.
- TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), Continued Health Care Benefit Program (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.

Veterans Affairs benefits as Other Health Insurance (OHI)

If beneficiaries are entitled to VA benefits, they may choose whether to see a TRICARE or VA provider.

If beneficiaries are entitled to Medicare Part A, 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.

Learn more about 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 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.

TRICARE Prime coverage options

TRICARE Prime, TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) are managed care options offering the most affordable and comprehensive coverage. While ADSMs must enroll in a TRICARE Prime option, Active Duty Family Members (ADFM), retirees and their families and others may choose to enroll in TRICARE Prime or use TRICARE Select. ADSMs enrolled in Prime receive care at military hospitals and clinics. If civilian network care is required, the military hospitals and clinics will provide a referral. ADSMs enrolled in Prime cannot be treated outside of the military hospitals and clinics without a valid referral, including preventive services. ADSMs enrolled in TPR will have a civilian Primary Care Manager (PCM) and will obtain the majority of their primary and specialty care in the civilian network. In the TRICARE East Region, TRICARE Prime, TPR and TPRADFM require beneficiary enrollment with Humana Military.

See instructions on verifying patient eligibility

TRICARE Prime

TRICARE Prime is a managed care option available in TRICARE Prime Service Areas (PSA). 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 enroll in 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 health care services.

A military hospital or clinic has the opportunity to provide specialty care for TRICARE Prime referrals for 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 their ADSM 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 may be eligible to enroll in TPR or TPRADFM.

Each TPR or TPRADFM enrollee is assigned a PCM unless one is not available in their area. In that scenario, the beneficiary would have an unassigned PCM until a network PCM becomes available.

TPRADFM beneficiaries should always seek non-emergency care from their PCMs unless they're using the Point-of-Service (POS) option. In most cases, a 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 Contract (SPOC). The SPOC determines referral management for fitness-for-duty care.

Note: TPR and TPRADFM do not require referrals for urgent care. They may seek urgent care without a referral from any TRICARE-authorized urgent care center or network provider.

TRICARE program options

TRICARE Prime Point-Of-Service (POS) option

The POS option allows non-Active Duty Service Members enrolled in TRICARE Prime or TPRADFM to seek non-emergency healthcare services from any TRICARE-authorized provider without referrals.

The POS cost-share applies when:

- The patient receives clinical preventive services from a non-network provider without a referral
- 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 facility specialty care provider
- The patient enrolled at a military hospital 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:

- Active Duty Service Members (ADSM)
- 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.

POS deductible and cost-share amounts for TRICARE Prime enrollees:

- Enrollment or calendar year deductible for outpatient claims (deductible amounts do not apply to inpatient claims): $300 per individual; $600 per family.
- Beneficiary cost-share for inpatient and outpatient claims: 50 percent of the allowable charge after the deductible has been met.

TRICARE Select

TRICARE Select is available to any non-active duty TRICARE-eligible beneficiary who has not enrolled in TRICARE Prime.

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.

Learn more about cost information from TRICARE

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 ADSM or National Guard and Reserve members on active duty. However, similar to TRICARE, 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 patient for whom the military facility provider maintains responsibility. In addition, SHCP-eligible service members may include members in travel status (leave, temporary duty, permanent change of station), Navy/Marine Corps service members enrolled to deployable unit and referred by the unit PCM, eligible National Guard and Reserve personnel, Reserved Officer Training Corps (ROTC) students, cadets/midshipmen and eligible foreign military.

Verify SHCP patient eligibility now

SHCP covers care referred or authorized by the military hospital or clinic and/or the Defense Health Agency – Great Lakes (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 facility, an electronic referral will be forwarded to Humana Military before the patient receives specialty care in the civilian healthcare system. Humana Military and the military clinic, as appropriate, identify a civilian provider and notify the patient. For non-military hospital or clinic- referred care, the DHA-GL/Specified Authorization Staff (SAS) determines if the ADSM receives care from a military hospital or civilian provider. SHCP beneficiaries are not responsible for cost-shares, copays or deductibles.

See Supplemental Health Care Program (SHCP)

Warrior Navigation and Assistance Program (WNAP)

WNAP was created to help guide warriors and their families through the military and Veteran Affairs' healthcare systems, by connecting them with community resources, non-medical services and civilian healthcare in order to help them return to productive lives. Returning warriors and their families can reach out for person-to-person support from a team that is specially trained to deal with the unique challenges they encounter.

Learn more about WNAP

TRICARE For Life (TFL)

TRICARE For Life (TFL) is Medicare wraparound coverage for TRICARE beneficiaries who have Medicare Part A and Medicare Part B, regardless of age or place of residence. With TFL, beneficiaries can seek care from any Medicare-participating or non-participating civilian provider or at a military hospital or clinic on a space-available basis. Enrollment is not required, but beneficiaries must pay Medicare Part B premiums.

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 for Medicare Part B later may have to pay a Medicare 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 Defense Enrollment Eligibility Reporting System (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.

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

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

TFL beneficiaries must present valid uniformed services 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, *TRICARE Medicare Eligible Program (TMEP), formerly named TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC), at (866) 773-0404. Call the Social Security Administration (SSA) at (800) 772-1213 to confirm a patient's Medicare status.

*The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) is now called TRICARE Medicare Eligible Program (TMEP).

TRICARE program options

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 PSA) 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 TRICARE referral and authorization requirements

File TFL claims first with Medicare. Medicare pays its portion and electronically forwards the claim to TRICARE Medicare Eligible Program (TMEP), (unless the beneficiary has OHI). TMEP sends its payment for TRICARE-covered services directly to the provider. Beneficiaries receive Medicare summary notices and TRICARE Explanation Of Benefits (EOB) 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 all billed charges.

See claims processing and billing for TFL claims and coordinating with OHI

TFL resources:

TMEP: (866) 773-0404
TRICARE4u.com
Costs and Fees

TRICARE for the National Guard and Reserve

National Guard and Reserve members and their families may qualify to purchase TRICARE Reserve Select (TRS), a premium-based health plan. Additionally, National Guard and Reserve members and their families may be eligible for regular TRICARE benefits when activated or on certain military orders.

Learn more about 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
- US Coast Guard Reserve

TRICARE Reserve Select (TRS)

TRS is a premium-based health plan that members of the Selected Reserve Component may qualify to purchase.

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

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 TRICARE 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 more on verifying patient eligibility.

Learn more about TRS

TRICARE program options

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.

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 TRICARE 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 more on verifying patient eligibility.

Learn more about TRR

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

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

This includes the member's travel time 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.

Notes: The Defense Enrollment Eligibility Reporting System (DEERS) does not show eligibility for LOD care. If a National Guard or Reserve member presents for emergency or urgent care that may be related to LOD, please render care and submit the claim even if the service member is not showing as eligible in DEERS.

If the provider uses a clearinghouse, they are not able to submit an electronic claim for LOD care; they can only submit a paper claim.

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
- Whenever possible, military hospitals and clinics provide care to National Guard and Reserve members with LOD conditions. These facilities 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 Great Lakes (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 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

Learn more about LOD from TRICARE

TRICARE program options

Coverage when activated more than 30 consecutive days

Reserve component 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 Active Duty Service Members (ADSM) 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 reserve components may also become eligible for TRICARE if the National Guard or Reserve member (sponsor) is called to active duty for more than 30 consecutive days. These family members may enroll in TRICARE Prime or TPRADFM, depending on location, or they may enroll in TRICARE Select. They are also eligible for dental coverage through TRICARE Dental Program (TDP). Sponsors must register their family members in DEERS to establish TRICARE eligibility.

TRICARE Young Adult (TYA)

TRICARE Young Adult (TYA) 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. Qualified dependents may purchase TYA Select, or if they reside in a Prime Service Area (PSA), they have the option to purchase TYA Prime.

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 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

Learn more about TYA

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 US.

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

TRICARE Extended Care Health Options (ECHO)

TRICARE ECHO provides services to Active Duty Family Members (ADFM) who qualify based on specific behavioral or physical disabilities. It offers beneficiaries an integrated set of services and supplies beyond those offered by basic TRICARE health benefit programs (e.g., TRICARE Prime, 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 intellectual disability
- 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 intellectual disability or a serious physical disability
- Multiple disabilities, which may qualify if there are two or more disabilities affecting separate body systems
- Participating in the Autism Care Demonstration (ACD) – see TRICARE Operations Manual (TOM), Ch. 18, Sec. 3 for details.

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.

Learn more about EFMP

ECHO provider responsibilities

TRICARE providers, especially PCMs, are responsible for managing catre 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 both 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 PGBA.

ECHO benefits

ECHO provides coverage for the following products and services:

- Assistive services (qualified interpreter or translator)
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)
- Rehabilitative services and hippotherapy (with a diagnosis of multiple sclerosis or cerebral palsy)
- 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 US Virgin Islands)
- EHHC respite care: Up to eight hours per day, five days per week to give caregivers time to sleep
- Training to use special education and assistive technology devices
- Institutional care when a residential environment is required
- Transportation to and from ECHO authorized service for an institutionalized ECHO beneficiary

Learn more about ECHO and the ACD

Note: All ECHO services require prior authorization from Humana Military.

ECHO costs

The government's limit for the cost of ECHO services combined (excluding EHHC) is $36,000 per beneficiary per calendar year. Beneficiaries are responsible for ECHO cost-shares in addition to cost-shares for basic TRICARE benefits.

ECHO monthly cost-shares are based on the sponsor's pay grade during months in which an ECHO service is received. The cost-share is applied only one time per month.

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

To learn more about ECHO benefits, contact a local ECHO case manager at (800) 444-5445.

Autism Care Demonstration (ACD)

The ACD provides TRICARE reimbursement for Applied Behavior Analysis (ABA) services to TRICARE-eligible beneficiaries diagnosed with Autism Spectrum Disorder (ASD, F84.0). To be eligible, beneficiaries must:

- Be enrolled in an eligible TRICARE plan option
- Receive a definitive diagnosis of ASD using the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition DSM-5 (or current edition) criteria by an approved ASD diagnosing provider (Primary Care Manager (PCM)) or specialized ASD-diagnosing provider

Eligible beneficiaries for the ACD must:

- Have proof of a definitive diagnosis, including initial date of diagnosis, through either a referral reflecting a diagnosis of ASD or a diagnostic evaluation and the DSM-5 criteria documented in a DHA-approved checklist
  - A parent questionnaire alone is not sufficient for diagnostic documentation.
- Submit one of the following validated assessment tools administered by a TRICARE-authorized diagnosing provider (see *TOM Ch. 18, Sec. 4, Par. 11.13* for complete list) and results must be submitted to the contractor:
  - *Screening Tool for Autism in Toddlers and Young Children (STAT)*
  - *Autism Diagnostic Observation Schedule-Second Edition (ADOS-2)*
  - *Autism Diagnostic Interview-Revised (ADI- R)*
  - *Childhood Autism Rating Scale-Second Edition (CARS-2)*
  - *Gilliam Autism Rating Scale, Third Edition (GARS-3)*
- Be enrolled in their service's EFMP and registered in ECHO to receive ABA under the ACD if they are a dependent of an ADSM
- Obtain referral and prior authorization for ABA services and meet all requirements of the ACD (TOM Ch 18. Sec. 4) in order for care to be reimbursable

Covered services under the ACD include:

- Autism services coordination via the ASN
- ABA services
- Complete all outcome measures as required by policy: Pervasive Developmental Disorder Behavior Inventory (PDDBI)/Parental Stress Index (PSI)/Stress Index for Parents of Adolescents (SIPA), Vineland 2 and Social Responsiveness Scale (SRS). All are due at baseline and every six months or annually: PDDBI/ PSI/SIPA are due with every six-month reauthorization; Vineland 2 and SRS 3 are due every year.

Exclusions/Non-covered services under the ACD include (see *TOM Chapter 18 Section 3 paragraph 8.10* for full list):

- Training of Behavioral Therapist (BT)
- ABA services for any other diagnoses other than ASD
- ABA services are not covered for symptoms and/or behaviors that are not part of the core symptoms of ASD (i.e., impulsivity due to ADHD, reading difficulties due to learning disability, excessive worry due to anxiety disorder, etc.)
- Billing for emails and phone calls
- Billing for driving to and from ABA services appointments (i.e., beneficiary's house, clinic, or other locations). Mileage/time traveling is not to be billed to the TRICARE program
- Rendering and billing for ABA services involving any aversive techniques or restraints
- Educational/academic and vocational rehabilitation. All educational/academic and vocational goals must be removed from the TP prior to approval by the contractor
- The contractor shall authorize and reimburse only CPT code 97153 rendered by the authorized ABA supervisor (not delegated to the assistant or BT) in the school setting
- Autism schools are not TRICARE-authorized providers. If an Autism school has a clinic setting as part of their offered services, the clinic must have a separate tax ID number

Please review the ACD policy (TOM Ch. 18, Sec. 4) in its entirety for complete overview of TRICARE requirements for ACD participation and policy exclusions.

Transitional healthcare benefits

TRICARE offers three options for beneficiaries separating from active duty or who are losing TRICARE eligibility:

- Transitional Assistance Management Program (TAMP)
- Transitional Care for Service-Related Conditions (TCSRC)
- Continued Health Care Benefits Program (CHCBP)

See eligibility for transitional healthcare benefits

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.

Qualifying beneficiaries may enroll in TRICARE Prime if they reside in a Prime Service Area (PSA), or they can enroll in TRICARE Select.

TRICARE program options

TAMP beneficiaries must present valid uniformed services ID card or CAC at the time of service.

Note: TAMP does not cover Line-of-Duty (LOD) Care.

See LOD Care for National Guard and Reserve members

Learn more about TAMP

Transitional Care for Service-Related Conditions (TCSRC) program

TCSRC 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 Department of Defense (DoD) physician

The TCSRC benefit covers care only for the specific service-related conditions. Preventive and health maintenance care is not covered. If a military hospital or clinic is not available, TCSRC beneficiaries may seek care from a TRICARE-authorized civilian provider. There are no copays or cost-shares under TCSRC and providers must submit claims to Humana Military. The TCSRC benefit is available worldwide.

Learn more about TCRSC

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 care with military hospitals or clinics.

Providers must coordinate with Humana Military to obtain necessary referrals and authorizations for CHCBP beneficiaries. Medical necessity rules for CHCBP beneficiaries follow TRICARE Select guidelines.

- To coordinate CHCBP referrals and authorizations, call (800) 444-5445
- Email behavioral health CHCBP referrals and authorizations to HBH_Military@humanamilitary.com or call (800) 444-5445

Learn more about CHCBP

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®.

To fill prescriptions, beneficiaries need a valid prescription and a valid uniformed services ID card or Common Access Card (CAC).

TRICARE beneficiaries have the following options for filling prescriptions:

- **Military hospital or clinic pharmacies**: A military pharmacy is the least expensive option, and formularies may vary by location. Contact the local military hospital or clinic pharmacy to check availability before prescribing medication. Use the TRICARE Formulary Search Tool (FST) to check the cost of a medication, formulary status, prior authorization requirements and forms needed to process a patient's prescriptions

TRICARE program options

- **TRICARE home delivery**: This method is another option when not using a military pharmacy for maintenance medications. This method adds convenience and provides cost savings for the beneficiary and the DoD. Prescriptions may be sent to home delivery through:
  - Electronically using e-prescribe (Express Scripts Home Delivery)
  - Fax: (877) 250-8255
  - Phone: (877) 283-3858
  - Mail: Express Scripts
    PO Box 52150
    Phoenix, AZ 85072-9954

Beneficiaries may also contact Express Scripts at (877) 363-1303 and request to have any existing prescriptions transferred to home delivery.

- **TRICARE network retail pharmacies:** Beneficiaries can access a network of retail pharmacies in the United States and US territories (Guam, the Northern Mariana Islands, Puerto Rico and the US Virgin Islands).

Find a TRICARE network pharmacy

- **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:** The fastest way to send a prescription is through electronic prescribing (e-prescribe). E-prescribing reduces prescribing errors and is available for providers to use through their preferred Electronic Health Record (EHR). Military providers located at a facility can utilize MHS GENESIS to e-prescribe directly to home delivery, retail pharmacies and other military pharmacies.

To e-prescribe through your EHR:

Verify with your patients their preferred pharmacy.

If their preferred pharmacy is TRICARE home delivery, select:

Express Scripts Home Delivery
4600 North Hanley Road
St. Louis, MO 63134

To e-prescribe to a military pharmacy:

All military pharmacies are listed as DoD “Site Name” ePhcy
Example: DoD FT Drum ePhcy

Prescriptions for controlled substances can be e-prescribed to military pharmacies. Prescriptions sent to home delivery or retail follow state-controlled substance laws.

Learn more about pharmacy benefits

Beneficiaries can manage prescriptions through their TRICARE Pharmacy account or with the Express Scripts Pharmacy mobile app. These allow the patient full visibility and management of their medication regardless of the Point-Of-Service (POS) they use for dispensing.

Learn more about the TRICARE Pharmacy Program

Get helpful information on the CDCs guidelines for prescribing opioids for pain

Generic drug use policy

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

If a patient requires a brand-name medication that has a generic equivalent, the provider must submit documentation of medical necessity to Express Scripts for prescribing the brand-name drug in place of its generic equivalent. 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. If there is a generic available, but the brand-name drug is a preferred drug, TRICARE beneficiaries may be able to receive the prescription at the generic copayment. To discover cost and coverage details and search for medications using the TRICARE Formulary Search Tool (FST).

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.

Search a general list of TRICARE-covered prescription drugs that have quantity limits

TRICARE Pharmacy prior authorizations or medical necessities

Medications requiring prior authorization may include, but are not limited to, prescription drugs specified by the DoD Pharmacy and Therapeutics Committee (DoD P&T), brand name medications with generic equivalents, medications with age limitations and medications prescribed for quantities exceeding normal limits.

Visit TRICARE Formulary Search Tool for current TRICARE-covered drugs/products requiring prior authorization or medical necessity

See the general list of TRICARE-covered prescription drugs requiring prior authorization

- **ADSMs:** ADSMs may receive non-formulary medications through a TRICARE Pharmacy 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 or at retail network pharmacies

For medical necessity to be established, generally 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

Learn more about medications and common drug interactions, check for generic equivalents or determine if a drug is classified as a non-formulary medication

Step therapy

Step therapy means trying a preferred drug as the first step in treating a medical condition. The preferred drug is:

- Safe
- Clinically effective
- Cost-effective
- Often a generic drug

Beneficiaries can get non-preferred drugs, but only if the preferred drug is not effective or tolerated well. This means the preferred drug must be tried first.

Note: If a beneficiary has tried the preferred drug or drugs in the time-frame designated by DoD P&T, usually 180 days, the non-preferred drug will process for that beneficiary for as long as they consecutively fill it.

Pharmacy benefits for Medicare-eligible beneficiaries

Express Scripts administers the TRICARE Pharmacy benefit and offers both retail and home delivery options.

Learn more about the TRICARE Pharmacy benefit

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. All other 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 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.

For the most up-to-date information on the Medicare Part D prescription drug benefit, beneficiaries should call Medicare.

Specialty medication

Specialty medications are usually high-cost, 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.

TRICARE beneficiaries have options for filling their specialty prescriptions.

Beneficiaries can fill their specialty medication at military pharmacies, if the specialty drug is in stock, TRICARE Home Delivery, where Accredo provides specialty pharmacy services, or a retail network pharmacy.

Accredo Specialty Pharmacy provides specialty pharmacy services to beneficiaries filling specialty medications through TRICARE Home Delivery. Accredo is an accredited specialty pharmacy serving patients with complex and chronic health conditions.

***Note:** If a beneficiary selects to use Accredo as their specialty pharmacy, the prescription can be sent to Accredo in four ways:

- e-Prescribe (via MHS GENESIS)
- e-Prescribe via MyAccredoPatients.com
- Fax by accessing a referral fax form
- Phone by calling (844) 567-8519

Accredo Specialty Pharmacy provides expanded services including:

- Specialty-trained pharmacists and nurses available 24 hours a day, seven days a week
- Condition-specific support from clinicians
- Dieticians, social workers and patient care advocates work together to get patients the necessary support
- Date-specific scheduling that allows patients to determine the date they prefer their prescriptions to be delivered
- Ancillary supplies

These services are provided to beneficiaries at no additional cost when they receive their medications through TRICARE Home Delivery where Accredo provides specialty pharmacy services. If a patient orders a specialty medication through TRICARE Home Delivery, Accredo will call your patient to schedule free, timely delivery to their home or your provider's office location, on a date that works best for the patient and your protocols.

If a patient requires specialty pharmacy medications, e-prescribe or fax the prescription to Express Scripts. When faxing the prescription, send to Express Scripts at (877) 895-1900 and include: patient's full name, date of birth, address and ID number.

To mail in the prescription to Express Scripts, use the below address:

Express Scripts
PO Box 52150
Phoenix, AZ 85072-9954

Note: Some specialty medications may not be available through at home delivery through Express Scripts Pharmacy because the manufacturer limits the drug's distribution to specific pharmacies. If providers submit a prescription for a limited- distribution medication, Express Scripts Pharmacy 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.

Determine if a specialty medication is available

Limitations and exclusions

View a complete list of care services that are generally not covered under TRICARE or are covered with significant limitations.

TRICARE dental options

The TRICARE healthcare benefit covers adjunctive dental care. However, several non-adjunctive dental care options are available to eligible beneficiaries.

ADSMs receive dental care at military Dental Treatment Facilities (DTF) 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 Federal Employees Dental and Vision Insurance Program (FEDVIP). FEDVIP has replaced the TRICARE Retiree Dental Program (TRDP). Each program is administered by a separate dental contractor and has its own monthly premiums and cost-shares.

Note: TRICARE may cover some medically necessary services in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, intellectual or physical disabilities and for children age five years and younger.

Learn more about TRICARE dental

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.

Learn more about ADDP

TRICARE Dental Program (TDP)

TDP, administered by United Concordia, is a voluntary dental insurance program available to eligible Active Duty Family Members (ADFM) and National Guard and Reserve and Individual Ready Reserve members and their eligible family members.

ADSMs (and some 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.

Learn more about TDP

For more information, call United Concordia at (844) 653- 4061 (in the continental US) or (844) 653-4060 (outside the continental US).

Federal Employees Dental and Vision Insurance Program (FEDVIP) dental and vision coverage

Dental and vision plans are available through the Office of Personnel Management's Federal Employees Dental and Vision Insurance Program (FEDVIP).

If a beneficiary is eligible, the next opportunity to enroll in FEDVIP is during TRICARE's open enrollment period (Open Season) every November.

Note: Children enrolled in or eligible for TRICARE Young Adult (TYA) are not eligible for FEDVIP. Beneficiaries enrolled in Transition Assistance Management Program (TAMP) are not eligible for FEDVIP.

For more information:

Phone: (877) 888-3337
Website: BENEFEDS

US Family Health Plan (USFHP) information

Under the US Family Health Plan (USFHP), Designated Providers (DP) are selected civilian medical facilities around the US assigned to provide care to eligible enrolled USFHP beneficiaries 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. Enrollment is open to people who are 64 years old or younger.

USFHP list of providers

- 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

Referrals and authorizations

TRICARE referrals and prior authorizations

If a necessary service is not available from the military facility or the beneficiary's Primary Care Manager (PCM), a referral will be required. Some procedures and services require prior authorization from Humana Military.

See a full list of services requiring prior authorization

The quickest, easiest way to request a referral or authorization or to check to see if a procedure code requires a referral or authorization is through provider self-service.

Log in to self-service now

Exception: Office-based/Telemedicine behavioral healthcare with a network provider does not require a PCM referral; however, if the provider is non-network, a referral is required.

Referral and authorization submission options

Providers should submit referrals and authorizations (including behavioral health) through self-service. Humana Military only accepts a faxed form if the provider is unable to submit them electronically.

View a tutorial for a step-by-step process of entering a new request and/or check/update an existing referral or authorization.

Submit via fax (only if unable to submit via the web):
Referrals and authorizations: (877) 548-1547
Behavioral health referrals and authorizations:
(877) 378-2316

Tips for making referrals and authorizations

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

- Self-service now offers online clinical questionnaires for certain services with benefit limitations, and completion of the questionnaire can expedite approval of your request, often resulting in immediate approval of services.
- 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.
- Up to five optimal provider choices will reflect 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 (40-mile radius), the services requested may be subject to redirection to the military hospital through the Right of First Refusal (ROFR).
- When completing the referral, always include the sponsor's TRICARE ID, diagnosis and clinical data explaining the reason for the referral.
- If the patient needs services beyond the referral's scope, the PCM must approve additional services.
- Check the status of the referral or authorization by logging in to provider self-service or by phone at (800) 444-5445.
- Humana Military will notify the beneficiary and provider of an approved referral or authorization.

Learn more about referrals and authorizations

Referrals and authorizations

Tips for hospital admission notifications

Submitting inpatient admission prior authorization requests and notifications online, including admissions for behavioral healthcare, is the quickest and most convenient way to communicate with Humana Military about a hospital admission. By using provider self-service, requests and notifications are streamlined. In many cases, the admission is immediately approved.

- Log in to provider self-service, select new request for referral or authorization, including hospital admission, and follow the 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, to complete the authorization and the claim to be properly processed.

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 (ADSM)
- Are subject to the military hospital or clinic ROFR policy

The referring specialist, the receiving specialist and the PCM will be notified of referrals through self- service or automatic fax.

If a pediatric patient age five or younger, or a patient with a developmental, intellectual 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
- Anesthesia for dental procedures
- Bariatric surgery
- Extended Care Health Option (ECHO) services
- Home health services, including home infusion
- Hospice
- Laboratory Developed Tests (LDT)
- Low-protein modified foods
- Open, arthroscopic and combined hip; Surgical for the treatment of Femoroacetabular Impingement (FAI)
- Spinal fusion, spinal cord stimulators and related procedures
- Transplants (solid organ and stem cell, not corneal transplant)

Inpatient stays:

- All non-emergent inpatient admissions (Notification of acute care admission is required by the next business day)
- Admissions or transfers to Skilled Nursing Facilities (SNF), rehabilitation and Long-Term Acute Care (LTAC)
- Continued stay review
- Discharge notification

Behavioral health:

- Applied Behavior Analysis (ABA) services
- Electroconvulsive Therapy (ECT)
- Non-emergency admissions, to include detoxification and rehabilitation services
- Psychoanalysis
- Residential Treatment Centers (RTC)
- Transcranial Magnetic Stimulation (TMS)
- Spravato™ (esketamine)

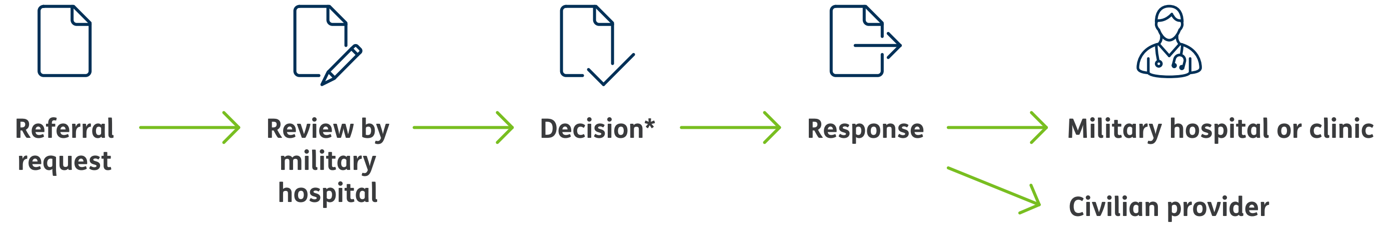
This list is subject to change.

Military hospitals and clinics and Right of First Refusals (ROFR)

To support readiness of the military medical force, military hospitals and clinics are afforded the opportunity to provide specialty care for TRICARE Prime beneficiaries who live within a 60 minute drive time of the facility.

When a network PCM submits a referral to Humana Military for a TRICARE Prime beneficiary to seek specialty care, Humana Military may send that request to the military hospital or clinic to determine if the care will be provided there.

The process for these specialty care referrals is outlined below.



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

The ROFR process

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

If the military hospital and clinic has the specialized services available and accepts the request, the military facility will notify Humana Military and the beneficiary will be referred to the military hospital or clinic. The military facility may contact the beneficiary to schedule an appointment, and Humana Military will provide the beneficiary with contact information for the military hospital or clinic.

If the military facility 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 can provide the services, and accepts the care, this overrides any prior provider selection requiring the beneficiary be seen at the military hospital. Failure to follow the ROFR referral to the military hospital or clinic will result in Point-Of-Service (POS) charges for the beneficiary.

Tips for ensuring the ROFR process is working in an office:

- Submit requests for specialty care referrals using provider self-service
- Submit pertinent clinical information with the referral
- Understand that even if a provider is submitted on the request, 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 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 costs for TRICARE beneficiaries
- To assist in determining prevalent military hospital and clinic specialty access and adequacy needs for a particular TRICARE population

Autofax confirmation

Providers are encouraged to use provider self-service to view approved referrals and authorizations. The detail page specifies the services authorized, the number of visits and the period in which the visits must occur.

An automatic fax may be sent and providers should program their office/referral fax number into their fax machine to ensure the number appears on their referral requests. The beneficiary will also receive notification of the approved referral or authorization via their preferred method of communication. Referring providers are responsible for notifying the beneficiary of urgent approval requests, as the beneficiary will not receive a copy of approved urgent care requests.

Medical coverage

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.

Learn more about covered clinical preventive services

Emergency care

TRICARE defines an emergency as a serious medical condition the average person would consider a threat to life, limb or eyesight or the ability to regain maximum function, or to prevent severe pain that cannot be adequately managed without the treatment requested requiring immediate medical care.

Examples of conditions that require emergency care include:

- Severe bleeding
- Chest pain
- Broken bone
- Sudden or unexpected weakness or paralysis
- Sudden changes in eyesight that could result in loss of vision or blindness
- Loss of consciousness
- Inability to breathe
- Spinal cord or back injury
- Poisoning
- Suicide attempt
- Drug overdose
- Loss of pulse
- Respiratory arrest
- Compartment syndrome

Included maternity-related emergencies involving a sudden unexpected complication which causes risk to the mother, the baby or both.

To avoid penalties, providers must notify Humana Military of any emergency admission through provider self-service within one business day of the admission.

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 may be responsible for paying Point-Of-Service (POS) fees.

Urgent care

Urgent care is medically necessary treatment that is required for a sudden illness or injury that is not life threatening, but does require immediate professional attention to avoid further complications resulting from non-treatment. Treatment is usually performed outside an Emergency Room (ER) setting.

Conditions that may require urgent treatment include earaches, sore throats, high fever or sprains. In many cases, the Primary Care Manager (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.

Learn more about urgent care coverage

Maternity care

Maternity care includes medical and surgical 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 an eligible sponsor.
- A newborn is covered as a TRICARE Prime or TRICARE Prime Remote (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.

Additional information regarding maternity benefit:

- Maternity care includes medical and surgical 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 is defined as a sudden unexpected medical complication which puts the mother or fetus at risk.

Referral and authorization requirements for maternity care

TRICARE Prime:

- The PCM for a pregnant beneficiary enrolled in TRICARE Prime must submit a referral request prior to the mother's first pregnancy-related appointment for global Obstetrician (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 Service Members (ADSM):

- 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.

- Hospitals are required to notify Humana Military of pre-term admissions

All TRICARE maternity admissions:

- 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.

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). See the below TRICARE manuals for more information.

Home healthcare
Home healthcare benefits for TRICARE ECHO
ADSM respite care coverage

Telemedicine

Telemedicine refers to the use of information and telecommunications technology to provide medically and psychologically necessary and appropriate diagnostic and treatment services across distances. Telemedicine may be conducted in many clinical specialties, including but not limited to, telemental health and teleprimary care.

TRICARE covers the use of secure video conferencing to provide medically and psychologically necessary services to beneficiaries at home. Specific technical requirements must be met and are outlined in TPM, Ch. 7, Sec. 22.1.

The services may be synchronous (two-way audio and video, such as real-time video) or asynchronous (one direction at a time, such as submitting medical history from one party to another).

Covered medically necessary telemedicine services include some:

- Office visits
- Preventive health screenings
- Telemental health services (individual psychotherapy, psychiatric diagnostic interviews and exams and medication management)

Telemedicine services do not include:

- Audio-only conferencing
- Phone calls
- Texting

The provider delivering telemedicine must be licensed in the state(s) in which the services are provided and received.

Telemedicine services are subject to the same authorization/referral requirements, criteria and limitations that apply to medical and psychological services.

The beneficiary is responsible for any applicable copay or cost-share. The copayment amount shall be the same as if the service was without the use of an interactive telecommunications system.

TRICARE For Life (TFL) should use Medicare guidance on telemedicine.

Telemedicine information for providers
Telemedicine FAQs
On demand webinars

Technical requirements

Video conferencing platforms used for telemedicine services must have the appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose and must meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and security rules. Video-chat applications (for example, Skype and FaceTime) may not meet such requirements and should not be used unless appropriate measures are taken to ensure the application meets these requirements and that appropriate business associates agreements (if necessary) are in place to utilize such applications for telemedicine.

Connectivity

Telemedicine services provided through personal computers or mobile devices that use internet-based videoconferencing software programs must provide such services at a bandwidth and with sufficient resolutions to ensure the quality of the image and/or audio received is sufficient for the type of telemedicine services being delivered. Telemedicine services shall not be provided if this functional requirement is not met.

Privacy and security

- Providers of telemedicine services shall ensure audio and video transmissions used are secured using point-to-point encryption that meets recognized standards.
- Providers of telemedicine services shall not utilize videoconference software that allows multiple concurrent sessions to be opened by a single user. While only one session may be open at a time, a provider may include more than two site/patients as participants in that session with the consent of all participants (e.g., group psychotherapy).
- Protected Health Information (PHI) and other confidential data shall only be backed up to or stored on secure data storage locations that have been approved for this purpose. Cloud services unable to achieve compliance shall not be used to PHI or confidential data.

Care via telemedicine

Telemedicine providers must be licensed or certified in accordance with appropriate state laws and federal regulations. When submitting claims for telemedicine services, the provider may indicate "Signature not required – distant telemedicine site" in the required patient signature field. Providers billing for telemedicine services will use CPT or HCPCS codes with an appropriate telemedicine modifier and indicate the place of service (where the beneficiary is physically located).

Synchronous telemedicine services (real-time, interactive care)

These services involve an interactive, electronic information exchange in at least two directions in the same time period.

Asynchronous telemedicine services (store and forward care)

These services involve storing, forwarding and transmitting medical information on telemedicine encounters in one direction at a time.

Submitting telemedicine claims

Telemedicine modifiers

Modifiers identify telemedicine services on claims and indicate how services are delivered to a beneficiary. Always select a modifier which accurately reflects the specific telemedicine encounter.

Telemedicine Place of Service (POS)

POS on a claim indicates the beneficiary location for the telemedicine encounter when receiving care, known as the originating site. The provider location, known as the distant site, does not determine the POS code. The beneficiary location, the origination site at the time of services rendered, dictates the POS. For an up-to-date list of POS codes, please refer to the Centers for Medicare and Medicaid Services (CMS) POS code set.

Examples using the POS code set:

- If a beneficiary is physically located at home during the telmedicine encounter, "POS 10 – telehealth provided in patient's home" would be denoted. Always select a POS which accurately reflects the specific telemedicine encounter.
- If a beneficiary is physically located in a hospital, facility or clinic setting (not a private residence) at time of telemedicine encounter, then denote "POS 02 – telehealth provided other than in patient's home," or a more appropriate POS code indicating facility type. Always select a POS which accurately reflects the specific telemedicine encounter.

Telemedicine originating site facility

The Healthcare Common Procedure Coding System (HCPCS) code "Q3014 – telehealth originating site facility," is billed if a beneficiary is in a healthcare facility when receiving telemedicine services. A distant site and originating site facility HCPCS Q3014 code cannot be billed by the same provider or when the patient's home is an originating site.

For more details on TRICARE's telemedicine policy, please see TRICARE Operations Manual (TOM), Ch. 27 Sec. 1.

Medical coverage

Infusion therapy

Infusion therapy delivered in the home requires a referral. Therapy may include:

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

The TRICARE medical benefit covers skilled nursing services, medical supplies and DME. The type of medication and dosage frequency will determine if the medication is paid through the medical or pharmacy benefit.

Learn more about home infusion therapy

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
- 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. Please see our procedure code lookup in provider self-service to check if a code is designated as “inpatient only.”

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 qualified patients treated in hospitals for at least three consecutive days (not including the day of discharge) prior to admission to the SNF facility 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. Hospice services require prior authorization. For more information about TRICARE’s hospice coverage, including concurrent hospice services and curative care for pediatric beneficiaries, refer to the TRM, Ch. 11, Sec. 2.

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 (chemo-sensitivity assays, bone density X-ray studies for routine osteoporosis screening).

TRICARE covers preconception and prenatal carrier screening for cystic fibrosis, spinal muscular atrophy, Fragile X syndrome, Tay-Sachs disease, hemoglobinopathies and conditions linked with Ashkenazi Jewish descent. Prior authorization is not required for preconception and prenatal carrier screening. Benefits for preconception and prenatal carrier screening are limited to one test per condition per lifetime.

TRICARE’s Laboratory Developed Test (LDT) Demonstration allows TRICARE to review tests not evaluated by the FDA for safety and effectiveness and gives beneficiaries access to LDTs usually not covered under the TRICARE basic benefit.

Prior authorization is required for all LDTs covered under the LDT demonstration. Providers must submit a completed LDT request and documentation to support necessity of testing for prior authorization and claims payment consideration. For the quickest processing to approval for prior authorization, providers should submit the request via provider self-service and attach the required documentation.

Note: A completed attestation form will be accepted in lieu of supporting clinical documentation for prior authorization requests and claim payment; however, the authorizations are subject to a routine audit that will include a request to the provider for supporting medical documentation. Laboratories performing LDTs must have Clinical Laboratory Improvement Amendments (CLIA) accreditation or certificate of compliance.

For additional information, visit the TRICARE Operations Manual (TOM), Ch. 18 Sec. 2.

Durable Medical Equipment (DME)

DME refers to equipment and/or supplies that are necessary for the treatment, habilitation or rehabilitation of a beneficiary.

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:** As a best practice, a length of need should not exceed a 12-month period. If a prescription/ order 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 if necessary. Length of need should be more than 12 months in the case of lifetime use.

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.

For more information, visit TPM, Ch. 8, Sec. 2.1.

Upgraded DME (deluxe, luxury and immaterial features)

TRICARE beneficiaries who choose to upgrade from a covered DME item to a deluxe, luxury or immaterial feature for comfort or convenience is responsible for the added cost. Refer to the TPM, Ch. 8, Sec. 2.1 for more information.

Providers must obtain a signed TRICARE non-covered services waiver form in advance of delivery of the DME in order to collect additional payment from the beneficiary for the additional cost due to upgraded or luxury items.

Referral and authorization guidelines for DME

All TRICARE Prime, TPR and TRICARE Young Adult (TYA) 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.

- ADSMs require an authorization for all DMEPOS items
- Predetermination is available for non-prime beneficiaries

Use the code look up tool on provider self-service to determine if a specific DMEPOS is covered or if a referral or authorization is required.

Notes: An approved authorization does not take the place of a CMN or physician's order. A completed and current CMN or physician's order is required to submit with the claim.

An approved military hospital or clinic referral authorization maybe submitted in place of a CMN if it includes are required information/

Referrals and authorizations are generally considered valid for six months to one year. Some DMEPOS may have a longer validity period to allow for rental to purchase. The beneficiary should return to his or her PCM annually for assessment of the condition and ongoing treatment/needs and obtain a new referral, if needed. Begin and end dates for referrals and authorizations are visible in provider self-service.

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. Refer to the TRM, Ch. 1, Sec. 11 for more information.

- **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.

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. For more information about covered services and treatments, refer to Mental Health Care | TRICARE Covered Services. All services and supplies provided by unauthorized providers are excluded from coverage. For information about the requirements for being a TRICARE-authorized provider, refer to the TPM, Ch. 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 facility's ability to render the care needed. When a service is not available at a military hospital or clinic, beneficiaries may seek behavioral healthcare from a TRICARE-authorized provider and, preferably, a network provider. Learn more about becoming a network provider.

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-5)* except "Conditions not attributable to a mental disorder," or **V** codes (**Z** codes in the *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)*), are not considered diagnosable mental disorders
- The symptoms are of a severity to cause significant distress
- The condition interferes 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.

Some groups of behavioral health providers can complete coursework in order to be listed in the provider directory with a provider readiness designation.

These providers include psychiatrists; clinical psychologists; certified psychiatric nurse specialists; certified clinical social workers; marriage and family therapists; TRICARE-certified mental health counselors; or certified pastoral counselors.

These providers can complete one of more of the following courses to obtain the provider readiness designation:

- The "Military Culture: Core Competencies for Healthcare Professionals" course developed by the DoD and the Department of Veterans Affairs/Veterans Health Administration (DVA/VHA) under the auspices of Integrated Mental Health Strategy (IMHS)
- The following courses offered by the Center for

Deployment Psychology (CDP) of the Uniformed Services University of the Health Sciences: "Cognitive Processing Therapy for Post-Traumatic Stress Disorder (PTSD) in Veterans and Military Personnel," "Prolonged Exposure (PE) Therapy for PTSD in Veterans and Military Personnel" and "Depression in Service Members and Veterans in evidence-based treatments

Expectations and standards of care

Incident reporting: Any serious occurrence involving a TRICARE beneficiary while receiving services at a TRICARE authorized treatment program (e.g., Residential Treatment Centers (RTC), freestanding Partial Hospitalization Program (PHP) or Substance Use Disorder Rehabilitation Facility (SUDRF)) must be reported to Humana Military by using provider self-service. If unable to use provider self-service, providers may call (800) 444-5445 or fax the behavioral health line (877) 378-2316 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 serious injury to a TRICARE beneficiary

Non-covered conditions and treatment

All services and supplies related to a non-covered 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 noncovered 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.

Non-covered services include but are not limited to the following:

- 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, 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 PTSD
- 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

View a complete list of behavioral healthcare services excluded under TRICARE or are covered with significant limitations.

Behavioral healthcare

Obtaining referrals and prior authorizations

See TOM Ch. 18, Sec. 4, Par. 8.6-8.6.2 for full list of referral and authorization processing requirements.

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

Providers who are not registered should register for an account.

Providers may no longer fax authorization requests

Provider self-service allows providers the ability to upload multiple documents to new and existing referrals and authorizations.

Active Duty Service Members (ADSM) must obtain a referral for all civilian care from their PCM. For all non-ADSMs, most outpatient behavioral healthcare visits from a TRICARE-network provider in your region do not require a referral. Certain outpatient behavioral healthcare services for non-ADSM TRICARE Prime enrollees do require a referral or pre-authorization, such as psychoanalysis and outpatient therapy for Substance Use Disorder (SUD). You may use the CPT code lookup in provider self-service to verify referral and prior authorization requirements.

Referral and authorization requirements for ABA services

A complete referral for Applied Behavioral Analysis (ABA) services under the Autism Care Demonstration (ACD) is required for all TRICARE-eligible beneficiaries.

ADSMs require referrals/authorizations from their Primary Care Manager (PCM) for all care, including behavioral health. If an ADSM does not have a referral, either you (provider) or the beneficiary should reach out to their PCM as soon as possible after care is rendered to obtain one.

- A referral must specify ABA services are being requested
- For beneficiaries first diagnosed with Autism Spectrum Disorder (ASD) at age eight years or older, and requesting ABA services on or after October 1, 2021, a specialized ASD-diagnosing provider evaluation (not a PCM), meeting all diagnosis requirements is required
- All ABA authorizations must be preauthorized; retrospective authorization is not allowed
- A validated assessment tool selected from this list (the most current edition): *Screening Tool for Autism in Toddlers and Young Children* (STAT), *Autism Diagnostic Observation Schedule-Second Edition* (ADOS-2), *Autism Diagnostic Interview-Revised* (ADI- R), *Childhood Autism Rating Scale-Second Edition* (CARS-2), *Gilliam Autism Rating Scale, Third Edition* (GARS-3)) must be administered by a TRICARE-authorized diagnosing provider, and results must be submitted to Humana Military
- A Defense Health Agency (DHA)-approved DSM-5 checklist documenting ASD criteria and the current level of support needed
- GARS-3 requires submission of diagnostic evaluation
- Upon receipt of the completed referral, Humana Military will issue an evaluation authorization for an initial assessment and treatment plan development
- Initial outcome measures must be completed prior to the start of ABA treatment
- Following the receipt of the TRICARE Operations Manual (TOM) compliant treatment plan, Humana Military will complete a clinical necessity and appropriateness of care review to make a subsequent approval for a six-month treatment and reassessment/treatment plan for active delivery of ABA services

Healthcare management

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 medical/surgical and behavioral health 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 reviews are completed quarterly on a statistical sample of paid claims as directed by TRICARE. Retrospective reviews may be performed on any service, but are typically focused on Diagnosis Related Group (DRG) reimbursement, home health services, hospice services and other specified topics as identified by TRICARE. Reviews are completed to ensure that reimbursed services are supported by the documentation in the beneficiary's medical record.

For claims identified as part of a retrospective review, a request for medical records will be mailed to the billing and/or rendering provider. Providers are required by TRICARE to comply with the request for records, and failure to do so could result in recoupment of payment for the services.

Discharge planning

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

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 case management via provider self-service or calling (800) 881-9227.

Clinical quality management

The clinical 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 make their medical records available for review for quality purposes.

A suspected clinical quality issue may be reported via provider self-service, phone at (800) 444-5445 or email to HealthcareQuality@humanamilitary.com.

TRICARE Quality Monitoring Contractor (TQMC)

Deloitte is the TQMC for the Defense Health Agency (DHA), and assists the DoD, DHA, military hospitals or clinic market managers and the Health Plan East Region office 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).

To facilitate TQMC reviews, providers' medical records may be requested by Humana Military on a monthly basis to comply with requirements detailed in the TOM, Ch. 7, Sec. 7. Providers may be required to submit records to Humana Military to comply with requests for medical records submitted by Deloitte 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 title 32 CFR 199.4(a)(5).

Medical records documentation

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

Peer Review Organization (PRO) agreement

Effective January 1, 2025, as the TRICARE East Regional Contractor, Humana Military will provide essential support and healthcare services for the states included in the TRICARE East Region and has review authority over healthcare services provided to beneficiaries of the Military Health System (MHS) in your institution.

To participate in the care of TRICARE beneficiaries, your institution must establish a **written agreement with the TRICARE contractor as incorporated into your Provider Agreement via the Provider Handbook, or through a signed document**, in accordance with 32 Code of Federal Regulations **(CFR) 199.2, 199.6, 199.15 [g]** and **TRICARE Operations Manual (TOM) 6010.59-M, April 1, 2015, Chapter 7, Section 1, par. 4.0)**.

- Institutional providers shall cooperate with the incoming contractor in the assumption and conduct of review activities.
- Institutional providers shall allocate adequate space for the conduct of on-site review.
- Institutional providers shall deliver to the incoming contractor a paper or electronic copy of all required information within 30 calendar days of a request for off-site review.
- Institutional providers shall provide all beneficiaries, in writing, their rights and responsibilities (e.g., "An Important Message from TRICARE" (Chapter 7, Addendum A), "Hospital Issued Notice of Noncoverage" (Chapter 7, Addendum B)).
- Institutional providers shall inform the incoming contractor within one business day if they issue a notice that the beneficiary no longer requires inpatient care.
- The contractor shall notify the Primary Care Manager (PCM) (if TRICARE Prime) within one business day of the inpatient discharge.
- Institutional providers shall assure that each case subject to preadmission or pre-procedure review has been reviewed and approved by the incoming contractor.

- Institutional providers shall agree, when they fail to obtain certification as required, that they shall 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)).
- Humana Military shall reimburse the provider for the costs of providing documents using the same reimbursement as Medicare.
- Humana Military shall provide detailed information on the review process and criteria used, including financial liability incurred by failing to obtain preauthorization.

Download the PRO agreement

Appealing a decision

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

Prior authorization appeals:

Appeals (preferred method)

Fax: (877) 850-1046

OR

Humana Military Appeals
PO Box 740044
Louisville, KY 40201-7444

Medical necessity determinations: are based on whether 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: 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 US 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 and 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
- TRICARE-allowable charge for services or supplies
- A beneficiary's eligibility (determination is the responsibility of the uniformed services)
- Provider sanction (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 plan is selected
- Denial of services by a PCM

Claims and billing information

Please note that all network providers are contractually obligated to submit claims electronically. Non-network providers have the option to submit paper claim forms, however, this may result in slower processing of claims.

Download the inpatient/outpatient claim forms

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.

TRICARE 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

For any questions regarding EDI, Electronic Remittance Advice (ERA) or Electronic Funds Transfer (EFT), call (800) 782-2680, option 2.

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 (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. For telemedicine services, the originating site provider may indicate "Signature not required – distant telemedicine site" in the required patient signature field.

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.

Intellectually 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.

Claims and billing information

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 behavioral or physical incapacity.

TRICARE electronic claims filing

Electronic claims filing offers:

- Faster claims processing
- Reduction of payment errors and data entry errors
- Immediate verification of claims received
- Electronic Data Interface (EDI) program edits minimize the impact of data entry errors at your office by information requirements
- Ease of use and support to assist with EDI transactions

Electronic Funds Transfer (EFT)

To sign up online for EFT, signature authority is required, which means the user is authorized to disburse funds, sign checks and add, modify or remove bank account information.

Balance-billing

A TRICARE network provider agrees to accept the rates and terms of payment specified in its Humana Military agreement 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.

TRICARE and TPL 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.

The beneficiary will be sent 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 within 35 calendar days before the claim can be processed and considered for reimbursement. Failure to return the completed form can result in claim denial

Inpatient claims submitted with diagnosis codes S0000XA to T889XXS 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).

Claims and billing information

Noncovered services

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

- Services that appear on the No Government Pay Procedure Code List
- 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: Active Duty Service Members (ADSM) may be covered for the above noncovered services on a case-by-case basis if 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.

Network providers should keep copies of the TRICARE noncovered services waiver form in their offices.

TRICARE Noncovered Services Waiver form

Hold-harmless policy

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

- If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary
- If the beneficiary was informed that services were excluded or excludable and agreed in advance and in writing to pay for the services
- If the beneficiary has been notified, in writing, that the service would not be covered for any reason

All TRICARE certified marriage and family therapists (network and non-network) sign a participation agreement with TRICARE as part of the certification process. By becoming TRICARE certified, all marriage and family therapists agree to hold beneficiaries harmless for non-covered care.

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. This includes the following:

- refunding the beneficiary any amount paid for the excluded services, including any deductible and cost-share amounts.
- refunding the beneficiary any payments made by the beneficiary or by another party on behalf of the beneficiary (excluding an insurer or provider) for the excluded services.

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

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 issues or questions regarding a TRICARE beneficiary who normally receives care in another TRICARE region, call the appropriate region-specific number for assistance.

Designated Providers (DP) are facilities that have contracts with the Department of Defense (DoD) to provide care to beneficiaries enrolled in the US Family Health Plan (USFHP). USFHP is offered in six geographic regions in the US.

Claims and billing information

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 (DP) 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 DP. Do not file USFHP claims with Humana Military.

Learn more about USFHP

Duplicate claims

Keeping unnecessary healthcare costs low is a responsibility of all members of the healthcare community. Providers should reconcile their financial records as soon as possible to avoid the impression of an unpaid balance.

Note: Wait at least 30 days before claims resubmission or telephone inquiry.

Check the status of a claim by logging into self-service

If, after reconciling accounts, it is determined payment has not been received or a provider disagrees with the payment amount, **do not resubmit the same claim**. Instead, explain the circumstance or disagreement by requesting a claim review and sending written correspondence to:

TRICARE East Region claims
ATTN: Routine Correspondence
PO Box 202147
Florence SC, 29502

Proper billing for multiple procedures

Do not use the same CPT code billed on multiple lines for the same date of service, instead use 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.

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.

Download Important Message from TRICARE form

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 a provider submits multiple claims on one patient's behalf, they must be submitted in chronological order. Hospital-based outpatient surgical procedures are reimbursed under the TRICARE Outpatient Prospective Payment System (OPPS). Some hospitals are exempt from OPPS. This is mandatory.

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 on the TRICARE's No Government Pay List and more information regarding TRICARE OPPS, refer to the TRM, Ch. 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 TPM, Ch. 9 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 Centers for Medicare and Medicaid Services (CMS) hospital classification.

Notification by the hospital must occur if the provider changes classification from a short term acute care hospital, Critical Access Hospital (CAH) or Sole Community Hospital (SCH) to any other of the three noted classifications. This 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
PO 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, TRICARE Prime Remote (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.

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
- 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.

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.

Determine if a TRICARE-allowable charge exists for specific drugs or vaccines

TRICARE and 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 Defense Health Agency (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
- All inpatient mental health, substance abuse disorder and residential treatment facilities (including detoxification and rehabilitation and all non-emergent care)
- All solid organ and stem cell transplants (excluding corneal transplants)
- Applied Behavior Analysis (ABA) services
- ICMP-PEC and CCTP services
- Electroconvulsive Therapy (ECT)
- Extended Care Health Option (ECHO) services
- Home health services, including home infusion
- Hospice
- Intensive Outpatient Program (IOP)
- Laboratory Developed Tests (LDT)
- Low protein modified foods
- Medication-Assisted Treatment (MAT)
- Open, arthroscopic and combined hip; surgical for the treatment of Femoroacetabular Impingement (FAI)
- Opioid treatment programs
- Partial Hospitalization Program (PHP)
- Psychoanalysis
- Psychological testing
- 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.

Claims and billing information

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.

Identify OHI in the claims 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

TRICARE and workers' compensation

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

Claims by TRICARE program

Beneficiaries using Medicare and TRICARE

TRICARE Medicare Eligible Program (TMEP)processes all TRICARE For Life (TFL) claims. Providers who currently submit claims to Medicare on a beneficiary's behalf do not need to submit a claim to TMEP. TMEP has signed agreements with each Medicare carrier allowing direct, electronic transfer of TRICARE beneficiary claims to TMEP. Beneficiaries and providers will receive Explanation of Benefits (EOB) from TMEP after processing.

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

Both participating and non-participating providers may bill Medicare. When TRICARE is the primary payer, all TRICARE requirements apply.

Refer to the TRM, Chapter 4, Sec. 4, 1.3.

North Atlantic Treaty Organization (NATO) beneficiaries

TRICARE covers NATO foreign nations' armed forces members who are stationed in the US or are in the US at the invitation of the United States government. They receive the same benefits as American ADSMs, including no out-of-pocket expenses for care if the care is directed by a military hospital or clinic.

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. They follow the same prior authorization requirements as TRICARE Select beneficiaries and are responsible for TRICARE Select cost-shares and deductibles. There is no catastrophic protection.

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.

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 Active Duty Family Members (ADFM).

Claims and billing information

Continued Health Care Benefit Program (CHCBP)

Send CHCBP claims to:

TRICARE East Region CHCBP Claims
PO Box 202146
Florence, SC 29502-2146

Extended Care Health Option (ECHO)

All claims for services billed under the ECHO benefit must have a valid written prior authorization and the beneficiary must show as enrolled in ECHO in Defense Enrollment Eligibility Reporting System (DEERS).

All claims for ECHO-authorized care (including ECHO Home Health Care and Autism Care Demonstration (ACD)) 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 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 TPM, Ch. 9, Sec. 4.1, 11.1, 14.1 and 18.1 for more information.

TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR)

All individuals covered under TRS should follow the applicable cost-shares, deductibles and catastrophic caps for Active Duty Family Members (ADFM) covered under TRICARE Select.

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

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

CHAMPVA is not a TRICARE program. It is administered by the VHA Office of Community Care.

VA Health Administration Center
CHAMPVA
PO Box 469063
Denver, CO 80246-9063
Phone: (800) 733-8387

Claims for current treatment must be filed within 365 days of the date of service. Providers may file healthcare claims electronically on behalf of their patients. To file a paper healthcare claim, download the CHAMPVA claim form and file within the one-year claim filing deadline.

Send claims to:

VHA Office of Community Care
CHAMPVA
PO Box 469064
Denver, CO 80246-9064

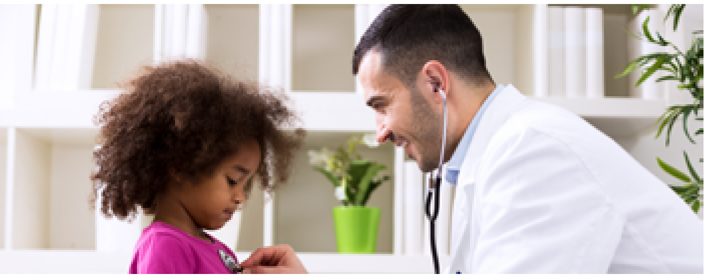
Providers may request a written appeal if exceptional circumstances prevented them from filing a claim in a timely fashion.

Send written appeals to:

VHA Office of Community Care
CHAMPVA
ATTN: Appeals PO Box 460948
Denver, CO 80246-0948

Note: Do not send appeals to the claims processing address. This will delay the appeal.

If a CHAMPVA claim is misdirected, it will be forwarded to the CHAMPVA Veterans Affairs (VA) Health Administration



Center in Denver within 72 hours and will send a letter to inform the claimant of the transfer.

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 US.

Overseas claims for National Guard and Reserve members on orders of 30 days or less should be sent to WPS. The orders verify the member's eligibility for TRICARE benefits. Learn more about submitting a TOP claim

Supplemental Health Care Program (SHCP)

Submit claims online through self-service or by mail.

Send all paper TRICARE claims to:

TRICARE East Region claims
PO Box 7981
Madison, WI 53707-7931

The same balance-billing limitations applicable to TRICARE apply to SHCP.

See balance-billing

TRICARE network providers

- File claims electronically on behalf of TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) beneficiaries in the same manner as filing other TRICARE claims.
- TRICARE will reimburse providers the remaining amount of the negotiated fee.

View cost-share information

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.

Learn more about TRICARE costs

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.

View current fee schedules

Durable Medical Equipment (DME) claims

Please mail requests to:

TRICARE East Region Claims
ATTN: New Claims
PO Box 7981
Madison, WI 53707-7981

Please include the supporting documentation with a paper claim; however, there is no guarantee the documentation will be kept with the claim once it arrives in the mailroom.

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 or 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.

Durable Medical Equipment procedures must be billed with a modifier. Modifiers used are (Not an all-inclusive list):

- RR Rental
- NU Purchase
- UE Purchase of used equipment

Capped rental items require an additional rental modifier KH, KI or KJ. These modifiers must be submitted in sequential order to avoid claim denial.

Replacement items must be submitted with the appropriate modifier (RA) and must include a Certificate of Medical Necessity that must indicate why the item is being replaced. Certificate of Medical Necessity (CMN) can be submitted prior to the claim to ensure its on file before a claim is received.

Medically Unlikely Edit (MUE) vs Day Units Time (DUT) 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. 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 before sending to claims processing. This field represents the number of units of an items being submitting. For example, in the observation world one unit = one hour.

Note: Do not file claims with future dates.

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

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

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. See coversheet and tips for filing a reconsideration. 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 payment will be issued on the line with the GK modifier as normal, 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 beneficiary.

Other claims and billing information

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
- Request an adjustment on an allowable charge review

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 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. DCAOs also cannot assist with claim concerns that are not in collections or have not resulted in an adverse credit rating. For claim concerns not related to a collection issue, customer service representatives are available to assist beneficiaries Monday - Friday, 8 AM - 6 PM (ET) at (800) 444-5445.

Find a DCAO location

Beneficiaries must take or submit documentation associated with a collection action or adverse credit rating to the DCAO. This documentation will include a completed and signed DCAO form and either a collection notice, a copy of the credit report or both showing a debt.

The DCAO will research the beneficiary's claim with the appropriate claims processor or other agency points of contact. Then, the DCAO will provide the beneficiary with a verbal resolution, or if the beneficiary cannot be reached, a written resolution to the collection problem. The DCAO will notify the collection agency that action is being taken to resolve the issue. In some instances, the beneficiary may owe the billed amount as part of their health plan co-pays, cost-shares and deductibles.

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.

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.

Fraud and abuse

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

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

Some examples of fraud include:

- Billing for services, supplies or equipment not furnished or used by the beneficiary
- Billing for costs of non-covered 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 maximum-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 US 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
- Providing services to an ineligible person and submitting the claim in the name of an eligible beneficiary

Some examples of abuse include:

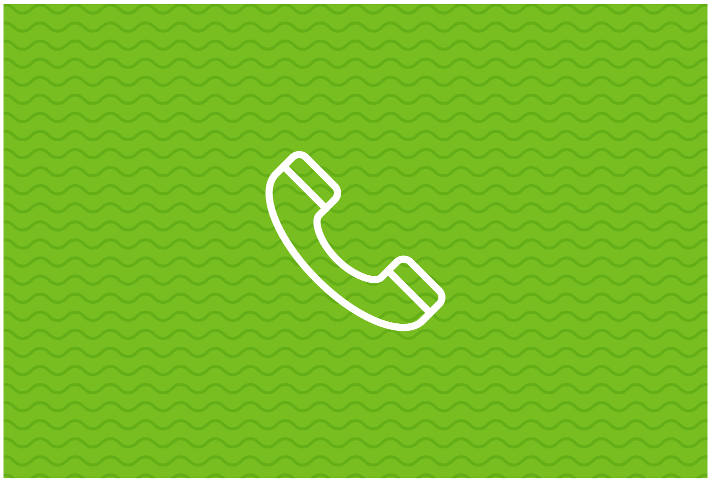
- A pattern of waiving beneficiary cost-share or deductible
- Charging TRICARE beneficiaries rates for services and supplies that are in excess of those charged to the public, such as by commercial insurance carriers or other federal health benefit entitlement programs
- A pattern of claims for services 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 upcoding, unbundling, fragmenting or code gaming to manipulate CPT codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such practices can be considered fraudulent and abusive.

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

The DHA Office of General Counsel works in conjunction with the program integrity branch to deal with fraud and abuse. The DoD Office of Inspector General and other agencies investigate TRICARE fraud.

To report suspected fraud and/or abuse, call the Humana Military fraud and abuse hotline at (800) 333-1620 or make a report online.



Other claims and billing information

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 a duplicate charge
- Charges denied as "included in a paid service"
- Claims auditing tool denials (except assistant surgeons)
- Claims denied as "Requested information was not received"
- Claims denied because Nonavailability Statement (NAS) is not in DEERS
- Claims denied because the provider is not a TRICARE-authorized provider
- Claims denied due to late filing
- Claims denied or payments reduced due to lack of authorization
- Coding issues
- Cost-share and deductible inquiries/disputes
- Eligibility denials/Beneficiary not in DEERS
- Keying errors/Corrected bills
- Network provider disputes relating to contractual reimbursement amount
- Other Health Insurance (OHI) denials/issues
- Point-Of-Service (POS) when reason for dispute is other than emergency care
- Prescription drug coverage
- Third Party Liability (TPL)
- Wrong procedure code

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

Appeals of claims denials

If a provider or a beneficiary has concerns about how a claim processed, an administrative review, also known as an allowable charge review, can be requested. It's important to differentiate allowable charge reviews from appeal requests. The appeal process is only applicable to charges denied as not covered or not medically necessary and are only accepted from appropriate appealing parties.

Note: Network providers are not proper appealing parties.

Administrative reviews

Providers can submit a request for an administrative review when there are concerns about how a claim processed. This process is separate from the appeals process.

The following are common reasons a provider may submit a request for administrative review, including:

- Allowed amount disputes
- Charges denied due to requested information not received
- Coding issues
- Cost-share and deductible issues
- Eligibility denials
- OHI issues
- Penalties for no authorization
- Point-of-Service (POS) disputes (POS for emergency services is appealable.)
- TPL issues
- Timely filing limit denials
- Wrong procedure code

How to submit an administrative review:

- Administrative reviews must be postmarked or received within 90 calendar days of the date of beneficiary's EOB or the provider remittance.
- For TRICARE purposes, a postmark is a cancellation mark issued by the US Postal Service. If the postmark on the envelope is not legible, the date of receipt is deemed to be the date of the filing.

Other claims and billing information

When requesting an administrative review, keep in mind the following:

- Request letters must state the reason for the requested review
- Be certain to include a EOB or provider remittance and
- Any additional documentation to support the request, including medical records
- Any new information not submitted with the original claim

Send requests for administrative reviews to:

TRICARE East Region claims department
PO Box 202147
Florence, SC 29502-2147

Claim appeals

Network providers are not a proper appealing party, but can appeal on behalf of the beneficiary with a signed *Appointment of representation* form from the beneficiary.

Claims that are denied by TRICARE due to medical necessity or a factual determination that a service is excluded by law or regulation are subject to the appeal process. The Explanation of Benefits (EOB) or provider remittance will indicate if a denied charge is appealable. If the EOB or remittance does not state the denied charge is appealable, the provider may request an allowable charge review instead.

The following are considered appealable issues:

- Claims denied due to TRICARE policy limitations
- Claims denied as not medically necessary
- Claims processed as POS only when the reason for dispute is that the service was for emergency care

Note: Network providers must hold the beneficiary harmless for non-covered care. Under the hold-harmless policy, the beneficiary has no financial liability and, therefore, has no appeal rights. However, if the beneficiary has waived his or her hold-harmless rights, the beneficiary may be financially liable and may have further appeal rights.

How to submit an appeal:

To submit an appeal on behalf of a beneficiary, a signed *Appointment of representative form* must accompany the appeal. Appeal 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 US Postal Service. If the postmark on the envelope is not legible, the date of receipt is deemed to be the date of the filing.

After a request is submitted, Humana Military will notify the appealing party in writing or by telephone of the outcome.

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

Note: A completed *Appointment of representative form* must be on file when representative is submitting an appeal on behalf of the proper appealing party.

When filing appeals, keep in mind the following:

- All appeal requests must be in writing and signed by the appealing party or the appealing party's representative.
- All appeal 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.

Other claims and billing information

- 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
- Proper appealing parties must meet the 90-day filing deadline, or the request for appeal will generally not be accepted

In addition, include the following information with an appeal:

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

Proper appealing parties may submit appeal requests via a secure, online self-service tool or via fax:

Fax: (877) 850-1046

TRICARE East Region Claims
Attn: Routine Correspondence
PO Box 202147
Florence, SC 29502-2147

TRICARE claims auditing

The TRICARE East Region uses a claims auditing tool to review claims on a prepayment basis. This clinical auditing tool contains specific logic designed to evaluate provider billing for CPT coding and to eliminate overpayment on 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.

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.

Send supporting medical record information to:

TRICARE East Region Claims
Attn: Routine Correspondence
PO Box 202147
Florence, SC 29502-2147

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

Learn more about submitting documentation

Find a claims address

Other claims and billing information

Payment guidelines

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 non-covered 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.
- 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.

Send all requests to:

TRICARE East Region Claims
PO Box 202146
Florence, SC 29502-2146

Reimbursement rates and methodologies are subject to change per DoD guidelines. For more information, refer to the TRM, Ch. 4.

Payer ID to electronic claims

In order to process claims payments under the TRICARE East Region contract, Humana Military changed the required payer ID to 99727. Please ensure that all claims submitted for the TRICARE East Region contain this payer ID.

Reimbursement methodologies

Anesthesia claims and reimbursement

Professional anesthesia claims must be submitted using the CPT anesthesia codes and number of time units. 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 service. In cases where an anesthesiologist provides a portion of the 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.

Anesthesia procedure pricing calculator

View TRICARE's anesthesia rates

Ambulance Fee Schedule (AFS) for TRICARE

The TPM, Ch. 8, Sec. 1.1 and TRM, Ch. 1, Sec. 14 and Ch. 5, Sec. 1-3 includes the change to AFS and provides detail on ground/air ambulance services, transfers and appropriate claim filing information.

Ambulatory Surgery Center (ASC) charges

All hospitals must submit claims for surgery procedures on a UB-04 claim form. Hospital-based ASC providers must use Type of Bill 13X. Freestanding ASCs may submit claims for surgery procedures on a CMS-1500 or UB-04 claim form.

Ambulatory Surgery Reimbursement

Beginning October 1, 2023, TRICARE adopted Medicare's ASC reimbursement system, including their fee schedule rules, payment rates, payment indicators, list of covered procedures and ancillary services, and wage indices.

These payment rates will only apply to the facility charges for a FASC. Refer to TRICARE Reimbursement Manual, Chapter 9, Section 2.

Hospital-based surgeries will be reimbursed under the Outpatient Payment Prospective System (OPPS).

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.
- No payment will be made for an assistant surgeon when co-surgeons are reimbursed.

See TRM, Ch. 1 Sec. 17

Reimbursement methodologies

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

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

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

Bonus payments calculations

For providers who are eligible and located in a Health Professional Shortage Area (HPSA), PGBA will calculate a quarterly 10 percent bonus payment from the total paid amount for TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TRICARE Select and TRICARE Reserve Select (TRS) 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 TRM, Ch. 1, Sec. 33.

Bonus payments in Health Profession Shortage Areas (HPSA)

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 US Department of Health and Human Services Health Resources and Services Administration's HPSA search tool at hpsafind.hrsa.gov.

View HPSA designations and bonus payment information

Calculating anesthesia reimbursement rates

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

This formula is used to calculate the TRICARE anesthesia reimbursement: (time units + RVUs) × conversion factor.

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

A base unit includes reimbursement for:

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

Services not included in the base unit include placement of arterial, central venous and pulmonary artery catheters and the use of 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 specialist begins to prepare the beneficiary for anesthesia 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 TRM, Ch. 9, Sec. 1.

Cancer and children's hospital reimbursement

Outpatient services provided by cancer and children's hospitals are subject to Outpatient Prospective Payment Systems (OPPS) for service dates on or after October 1, 2023. These facilities may be eligible for hold-harmless payments every year. Hold-harmless payments are based on Cost-to-Charge Ratios (CCR) instead of the payment-to-cost ratio. Hold-harmless payments are made annually and calculated within 180 days of the end of the OPPS year (April 1 through March 30). The Defense Health Agency (DHA) will calculate whether a hospital's costs exceed the actual payments made under OPPS. If so, the hospital will receive a payment adjustment to allow for 100% reimbursement of costs.

Cancer and children's hospitals can request a General Temporary Military Contingency Payment Adjustment (GTMCPA) within 12 months of the end of the OPPS year. DHA may approve GTMCPA payment for hospitals that service a disproportionate share of Active Duty Service Members (ADSM) and Active Duty Family Members (ADFM). Please see the TRICARE Reimbursement Manual (TRM) Chapter 13 for complete details.

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

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

- Hospital name
- Hospital address
- Hospital tax identification number
- Hospital Medicare provider number
- Time period covered (must correspond with the hospital's Medicare cost-reporting period)
- Total inpatient days provided to all beneficiaries in units subject to DRG-based payment
- Total TRICARE inpatient days, provided in "allowed" units, subject to DRG-based payment (excluding non-medically necessary inpatient days)
- Total inpatient days provided to Active Duty Service Member (ADSM) 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 PGBA within 30 days of the date the hospital is notified of the change. In addition, the provider's officer or administrator must certify all cost reports.

Diagnosis-Related Group (DRG) calculator

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 webpage. If a hospital is not listed in the wage indexes and Power of Attorney (POA) factors file, use the ZIP to wage index file to obtain the wage index for that area by ZIP Code.

View the DRG calculator

Diagnosis-Related Group (DRG) reimbursement

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

The grouper used for the TRICARE DRG-based payment system is the same as the Medicare grouper with some modifications, such as neonate DRGs.

For more details, see the TRM, Ch. 6.

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

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

DMEPOS prices are established by using the Medicare fee schedules, TRICARE fee schedules, reasonable charges or state-prevailing rates and average wholesale price. 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 or 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. A new CMN is required for a replacement item.
- **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.

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 Noncovered Services Waiver form on file in order to bill the beneficiary for the cost above the approved DME item.

View more on DMEPOS pricing information

Reimbursement methodologies

Filing claims for Partial Hospitalization Program (PHP) charges

The TRICARE OPPS pays claims filed for hospital outpatient services, including hospital-based PHPs (psychiatric and (Substance Use Disorder Rehabilitation Facilities (SUDRF)) 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. Although Medicare now only recognizes one level of PHP care (three units of service or more), TRICARE will retain a two-tiered system:

- **APC T5861:** For two hours of service or one occurrence of an IOP code (HCPCS codes S9480 or H0015) which will group to T0175
- **APC 05863:** For three or more units of service

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 TRM, Ch. 13, Sec. 1.

Home Health Agency (HHA) pricing

TRICARE pays Medicare-certified HHA using a Patient-Drive Grouping Model (PDGM) that is modeled after Medicare's plan. Medicare-certified billing is handled in 30-day care episodes.

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.

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 and intravenously 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.

Hospice pricing

Hospice programs are not eligible for TRICARE reimbursement unless they enter into an agreement with TRICARE. Reimbursement will be based on national Medicare hospice rates for 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

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.

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, such as Critical Access Hospitals (CAH).

TRICARE OPPS also applies to hospital-based Partial Hospitalization Programs (PHP) 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, DC and Puerto Rico
- Indian Health Service hospitals that provide outpatient services
- Specialty care providers, including:
- Cancer and children's hospitals (Dates of Service prior to October 1, 2023)
- Community behavioral health centers
- Comprehensive outpatient rehabilitation facilities
- VA hospitals
- Freestanding Ambulatory Surgery Centers (ASC)
- Freestanding birthing centers
- Freestanding end-stage renal disease facilities
- Freestanding PHPs (psychiatric facilities and Substance Use Disorder Rehabilitation Facilities [SUDRF])
- Home Health Agencies (HHA)
- Hospice programs
- Other corporate services providers (e.g., freestanding cardiac catheterization and sleep disorder diagnostic centers)
- Skilled Nursing Facilities (SNF)
- Residential Treatment Centers (RTC)

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).

Learn more about OPPS

Reimbursement methodologies

Present-On-Admission (POA) code descriptions

- **Y:** Indicates that the condition was present on admission
- **W:** Affirms that the provider has determined, upon data and clinical judgment, that it is not possible to document when the onset of the condition occurred
- **N:** Indicates that the condition was not present on admission
- **U:** Indicates that the documentation is insufficient to determine whether the condition was present at the time of admission
- **1:** Prior to fiscal year 2011, signified exemption from POA reporting. The Centers for Medicare & Medicaid Services (CMS) established this code as workaround to blank reporting on the electronic 4010A1. A list of exempt ICD-10-CM diagnosis codes is available in the ICD-10-CM Official Coding Guidelines. This exemption to POA reporting is not available for reporting on the electronic 5010.

As of fiscal year 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 data via 4010A.)

POA indicator

Inpatient acute care hospitals paid under the TRICARE DRG-based payment system are required to report a 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.

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

The following hospitals are exempt from POA reporting for TRICARE:

- Critical Access Hospitals (CAH)
- Long-term care hospitals
- Maryland waiver hospitals
- Cancer hospitals
- Children’s inpatient hospitals
- Inpatient rehabilitation hospitals
- Psychiatric hospitals and psychiatric units
- US Department of Veterans Affairs (VA) hospitals

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.

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 solo 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 where applicable.

A hospital which is not Medicare-participating and which is exempt from the program’s reimbursement method for hospitals (32 CFR 199.14), may elect to participate on a claim-by-claim basis.

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

Reimbursement methodologies

Skilled Nursing Facility (SNF) pricing

TRICARE pays Skilled Nursing Facilities (SNF) 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 TRM, Ch. 8, Sec. 1 and Sec.2.

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.

For full criteria of SCHs, read 42 (Code for Regulations) CFR 412.92.

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 number of beds and 25% of inpatient admissions

The TRICARE SCH policy can be found in TRM, Ch. 14, Sec. 1 .

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

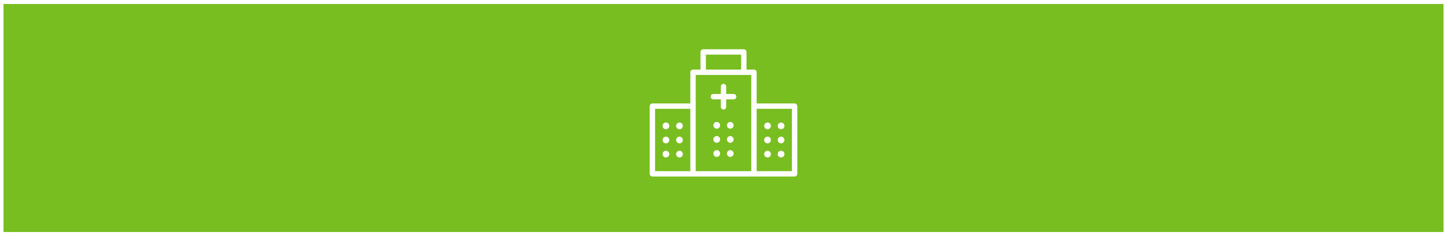
See the current state-prevailing rates

Surgeon's services for multiple surgeries

Multiple surgical procedures have specific reimbursement requirements. When multiple surgical procedures are performed, the primary surgical procedure 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.



Reimbursement methodologies

Tips for a final claim

- Network home healthcare providers must submit TRICARE claims electronically. The bill type in FL 4 must always be 329.
- 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 claim.
- The dates in FL 6 must be a range from the first day of the episode plus 29 days.
- Dates on all of the lines must fall between the dates in FL 6.

Tips for filing a Request for Anticipated Payment (RAP)

When filing a Request for Anticipated Payment (RAP), keep in mind the following:

To align with the Medicare Claims Processing Manual (CPM) Effective February 6, 2023, Humana Military will no longer accept Requests for Anticipated Payment (RAP) for periods of care beginning on or after January 1, 2022. However, the prior authorization process continues to apply on claims with from dates on or after January 1, 2022.

Provider tools and resources

Check eligibility

Forms

Claims information

Provider self-service

Education presentations

Self-guided provider orientation

Find a provider

Webinars

Acronyms

ABA	Applied Behavior Analysis
ACD	Autism Care Demonstration
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AFS	Ambulance Fee Schedule
ASC	Ambulatory Surgery Center
ASN	Autism Services Navigator
CAC	Common Access Card
CAH	Critical Access Hospital
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CHCBP	Continued Health Care Benefit Program
CLR	Clear and Legible Reports
CMAC	CHAMPUS Maximum Allowable Charge
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CSP	Corporate Service Provider
DBN	DoD Benefits Number
DCAO	Debt Collection Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DHA-GL	Defense Health Agency – Great Lakes
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies
DoD	Department of Defense
DRG	Diagnosis Related Group
DTF	Dental Treatment Facility
DUT	Day Units Time
DVA	Department of Veterans Affairs
ECHO	Extended Care Health Option
EDI	Electronic Data Interchange
EFMP	Exceptional Family Member Program
EHHC	ECHO Home Health Care
EOB	Explanation of Benefits
FY	Fiscal Year
GSA	General Services Administration
HEDIS	Healthcare Effectiveness Data and Information Set
HHA	Home Health Agency
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HPSA	Health Professional Shortage Area
IDME	Indirect Medical Education
IVR	Interactive Voice Response
LOD	Line Of Duty
LDT	Laboratory Developed Test
LTAC	Long Term Acute Care
MHS	Military Health System
MUE	Medically Unlikely Edit
NAS	Nonavailability Statement
NATO	North Atlantic Treaty Organization
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NPI	National Provider Identifier
OHI	Other Health Insurance
OPPS	Outpatient Prospective Payment System
PCM	Primary Care Manager
PHP	Partial Hospitalization Program
POS	Point-Of-Service
POA	Present on Admission
PHI	Protected Health Information
PPS	Prospective Payment System
PRO	Peer Review Organization

Acronyms

PSA	Prime Service Area
RAP	Request for Anticipated Payment
RTC	Residential Treatment Center
SCH	Sole Community Hospitals
SHCP	Supplemental Health Care Program
SNF	Skilled Nursing Facility
SPOC	Service Point Of Contact
SSA	Social Security Administration
SSN	Social Security Number
SUDRF	Substance Use Disorder Rehabilitation Facility
TAMP	Transitional Assistance Management Program
TCSRC	Transitional Care for Service-Related Conditions
TDP	TRICARE Dental Program
TFL	TRICARE For Life
TOP	TRICARE Overseas Program
TPL	Third Party Liability
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRR	TRICARE Retired Reserve
TRS	TRICARE Reserve Select
TYA	TRICARE Young Adult
URAC	Utilization Review Advisory Committee
TMEP	TRICARE Medicare Eligible Program
USFHP	US Family Health Plan
USPHS	US Public Health Service
VAMC	VA Medical Center
WNAP	Warrior Navigation and Assistance Program

Glossary of terms

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 (BCAC)

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). To locate a BCAC, visit HumanaMilitary.com/beneficiary/claims/bcac-dcao

Catastrophic cap

The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given Calendar Year. 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.

Glossary of terms

Search

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.

Laboratory Developed Test (LDT)

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

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/Calendar Year catastrophic cap has been met. The POS option is not available to ADSMs.

Glossary of terms

Search

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.

INDEX

A

Abuse 11, 12, 24, 48, 64

Active Duty Dental Program (ADDP) 35

acute care 38, 57, 75

Adjunctive dental 38, 58

Ambulance Fee Schedule (AFS) 69

Ambulatory surgery 69

Anesthesia 44, 69, 70, 71

Appeal 66

Applied Behavior Analysis 10, 29, 38, 58, 79

Assistant surgeon services 69

Autism 29, 30, 49, 60, 79

Autofax 39, 40

B

Balance-billing 54

Bariatric surgery 38

Behavioral healthcare 12, 19, 47, 48, 49, 70

Beneficiary rights and responsibilities 20

Billing 19, 30, 62, 64

Blood 44

Bonus payments 70

C

Cancer 74, 75

Capital and direct medical education 71

Case management 50

Centers for Medicare & Medicaid Services 75

CHAMPUS 24, 79, 81

CHAMPUS Maximum Allowable Charge 79, 81

Civilian Health and Medical Program of the Department of Veterans Affairs 60, 79, 81

Claims information 78

Claims reconsiderations 67

Clear and Legible Reports 19, 79

Clinical quality management 51

Common Access Card 21, 31, 79

Concurrent review 50

Continued Health Care Benefit Program 22, 31, 60, 79

Corporate Services Provider 17, 81

Credentialing 12, 82

Critical Access Hospital 57, 76, 79

D

Day Units Time 62, 79

Debt Collection Assistance Officer (DCAO) program 63

Defense Enrollment Eligibility Reporting System (DEERS) 21, 25, 27, 59, 60, 82

Denial 52

Diagnosis-Related Group 72, 75

Discharge planning 50

Duplicate claims 56

Index

E

ECHO Home Health Care 29, 60, 79

Edits 67

Electronic claims filing 54

Electronic Data Interchange 79

Electronic Funds Transfer 53, 54

Eligibility 21, 25, 27, 41, 59, 60, 65, 79, 81, 82

Emergency care 24, 41

Exceptional Family Member Program 28, 79

Exclusions 30

F

Fraud and abuse 64

G

Generic drug use policy 32

Global maternity claims 57

H

Healthcare Common Procedure Coding System 72

Healthcare Effectiveness Data and Information Set 8, 13, 79

Health Information Exchange 20, 79

Health Profession Shortage Areas 70

Hold-harmless 55

Home health 12, 17, 38, 58

Home infusion 17, 73

Hospice 38, 44, 58, 73, 74

Hospital and facility billing 56

Hospitalization 44, 58, 73, 74, 79

I

Important provider information 16, 17, 18, 19, 20

Indian Health Service 58, 74

Individual Ready Reserve 35

Infusion therapy 44

L

Limitations and exclusions 13, 35

Line-Of-Duty (LOD) care 27

M

Maternity care 41, 42

Medicaid 12, 20, 25, 57, 58, 61, 75, 76, 79, 81

Medical necessity 31, 52

Medical records documentation 51

Medicare 12, 20, 21, 22, 25, 26, 34, 36, 43, 44, 54, 56, 57, 59, 61, 70, 71, 72, 73, 74, 75, 76, 79, 82

Military ID cards 21

Missed appointments 17

Modifier 67, 70

Moonlighting providers 19

N

National Guard and Reserve 7, 24, 26, 27, 28, 31, 35, 58, 61

National Provider Identifier (NPI) 82

NATO beneficiaries 59

Network provider 52, 65

No Government Pay Procedure Code List 21, 55

Noncompliance 54

Noncovered services 55

Index

Nondiscrimination policy 17

Notice of Privacy Practices 9

Notices of Award 25

O

Office and appointment access standards 18

Orthotics 45, 61, 72, 79

Other Health Insurance 12, 22, 24, 54, 55, 65, 70, 79

Outpatient Prospective Payment System 56, 74, 75, 79, 82

P

Partial Hospitalization Program 58, 73, 79

Payment guidelines 68

Peer Review Organization (PRO) 51

Pharmacy benefits 34

Point-Of-Service (POS) 24, 32, 41

Pregnancy 50

Premature infant 50

Preoperative 67, 70

Prescription 65

Present-On-Admission (POA) 75

Preventive care 18

Primary Care Manager (PCM) 13, 16, 23, 29, 41, 57, 83

Prime Service Area (PSA) 28, 30

Prior authorization 38, 45, 52

Protected Health Information (PHI) 9, 43

Provider education 15

Provider responsibilities 17

Provider self-service 12, 78

Psychoanalysis 39, 48, 58

Psychological testing 58

Q

Quantity limits 32

R

Radiation therapy 17

Reconsideration 62

Referrals 13, 37, 38, 39, 40, 46

Rehabilitation 73, 74, 80

Reimbursement methodologies 69, 70, 71, 72, 73, 74, 75, 76, 77

Resources 70

Respite care 42

Retrospective review 50

Right to appeal 17

Routine care 16, 18

S

Signature on file 53

Skilled Nursing Facility (SNF) 44, 76

Social Security Act 63

Social Security Number (SSN) 59

Sole Community Hospitals (SCH) 76

Specialist 38

Specialty care 18, 74

Specialty medication care management 34

Sponsor 67, 83

State-prevailing rates 76

Index

Step therapy 33

Supplemental Health Care Program (SHCP) 24, 61, 83

Surgeon 76

T

Telemedicine 37, 43

Tips 37, 38, 40, 77

Transplant 50

TRICARE allowable charge 81

TRICARE-authorized provider 11, 17, 24, 26, 27, 47, 52, 64, 66, 69

TRICARE For Life (TFL) 22, 25, 43, 59

TRICARE Operations Manual 8, 17, 45, 51

TRICARE Overseas Program (TOP) 28, 61

TRICARE Pharmacy Program 31, 32, 34

TRICARE Policy Manual 8, 17, 43, 44, 45, 46, 47, 48, 57, 60, 69

TRICARE Prime 12, 16, 18, 21, 22, 23, 24, 25, 26, 28, 30, 36, 39, 41, 42, 46, 56, 57, 68, 70, 80, 81, 82, 83

TRICARE Prime Remote 16, 23, 41, 57, 70, 80

TRICARE Prime Remote for Active Duty Family Members 23, 70, 80

TRICARE Quality Monitoring Contractor 51, 80

TRICARE Reimbursement Manual 8, 44, 46, 48, 56, 59, 60, 68, 69, 70, 71, 73, 76

TRICARE Reserve Select 22, 26, 60, 61, 70, 80

TRICARE Retired Reserve 22, 27, 60, 61, 80

TRICARE Select 18, 22, 23, 24, 25, 26, 27, 28, 30, 31, 41, 42, 59, 60, 70, 81, 82

Trusted site information 14

U

Urgent care 16, 18, 19, 41

US Family Health Plan 22, 36, 55, 80, 82

V

Verifying benefit coverage 21

Verifying eligibility 21

Veterans Affairs 9, 20, 22, 60, 75, 79, 81

W

Warrior Navigation and Assistance Program 25, 80

Welcome to TRICARE and the East Region 7, 8, 9

Wisconsin Physicians Service 8, 28, 61

X

X-ray 44

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