October 2015

An Important Note about TRICARE® Program Information

This TRICARE Provider Handbook (Handbook) will assist you in delivering TRICARE benefits and services. At the time of publication, the information in this Handbook is current, but must be read in light of ever-changing governing regulations.

It is important to recognize that TRICARE policies and benefits are governed by federal regulations. Changes to TRICARE programs are continually made as federal regulations are revised and updated. Where required by law, updates will be provided in writing. We may also use additional channels (such as mail, internet, email, phone and fax) to communicate with you in the event of such a change. When required by law, we will notify you prior to implementation of a change.

To the extent that some requirements are applicable only in certain states at the time of printing, we have indicated that in this Handbook.

The codes and code ranges listed in this Handbook are current at the time of publication. Codes and coding requirements, as established by the organizations that create the codes, may periodically change. Please refer to the applicable coding guide for appropriate codes or visit us online for more information.

For the most recent information, visit UnitedHealthcare Military & Veterans (may also be referred to as UnitedHealthcare) at UHCMilitaryWest.com or call UnitedHealthcare Military & Veterans Customer Service at 877-988-9378. More information regarding TRICARE is available at tricare.mil.

Using This TRICARE Provider Handbook

This Handbook provides you and your staff with important information about TRICARE while emphasizing key operational aspects of the program and program options. This handbook will assist you in coordinating care for TRICARE beneficiaries. It contains information about specific TRICARE programs, policies, and procedures.

This Handbook is updated as needed, but not less than annually, and is available electronically on UHCMilitaryWest.com. You may request additional copies of the TRICARE Provider Handbook from UnitedHealthcare at 877-988-9378.

Thank you for your service to America’s heroes and their families.

For contact information, visit the “Contact Us” page on UHCMilitaryWest.com.
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Welcome to TRICARE and the West Region

What Is TRICARE?

TRICARE is the uniformed services* health care program for active duty service members and their families, retired service members and their dependents, members of the National Guard and Reserve and their families, survivors, and others who are eligible. TRICARE’s primary objective is to deliver world-class health care benefits for all Military Health System (MHS) beneficiaries that provide the highest level of patient satisfaction.

TRICARE brings together the health care resources of the uniformed services and networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide access to high-quality health care services while maintaining the capability to support military operations.

TRICARE is available worldwide. In the United States, TRICARE is divided into three separate regions – TRICARE North, TRICARE South, and TRICARE West.

In the United States, TRICARE is managed jointly by the Defense Health Agency (DHA) and TRICARE Regional Offices. DHA has contracted with civilian managed care support contractors in the North, South, and West regions of the United States to assist TRICARE regional directors and military treatment facility (MTF) commanders in operating an integrated health care delivery system.


TRICARE Regions

West Region
UnitedHealthcare Military & Veterans
Provider Services Line:
877-988-9378
UHCMilitaryWest.com

North Region
Health Net Federal Services, LLC
Customer Service Line:
877-TRICARE/877-874-2273
hnfs.com

South Region
Humana Military Healthcare Services, Inc.
Customer Service Line: 800-444-5445
humana-military.com
Your Managed Care Support Contractor

UnitedHealthcare is responsible for administering the TRICARE program for more than 2.9 million beneficiaries in the 21 state TRICARE West Region. The West Region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excluding the Rock Island Arsenal area), Kansas, Minnesota, Missouri (excluding the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner only, including El Paso), Utah, Washington, and Wyoming.

UnitedHealthcare is committed to preserving the integrity, flexibility, and durability of the MHS by offering TRICARE beneficiaries access to the finest health care services available, thereby contributing to the continued superiority of U.S. combat readiness.

PGBA, LLC. (PGBA)
PGBA is the UnitedHealthcare contractor for claims processing. PGBA has extensive experience with every aspect of TRICARE claims-processing activities, including the development of claims submission options. See the Claims Processing and Billing Information section of this Handbook for specific options and instructions for filing claims electronically. Filing claims electronically shortens reimbursement time and enhances the accuracy of submitted claims. More information about PGBA, as well as instructions for utilizing their services, can be found online at myTRICARE.com.

Provider Resources

Many national and regional resources are available if you or your staff members have questions or concerns about TRICARE programs, policies, or procedures; or if you need assistance coordinating care for a TRICARE beneficiary.

TRICARE Manuals Online

This Handbook is a summary of the TRICARE program regulations and requirements contained in the TRICARE Operations Manual 6010.56-M, February 2008, the TRICARE Policy Manual 6010.57-M, February 2008, and the TRICARE Reimbursement Manual 6010.58-M, February 2008. These manuals are available in their entirety online at manuals.tricare.osd.mil and are subject to change by DHA.

UnitedHealthcare Military & Veterans Website

Most care providers can register for secure access to UHCMilitaryWest.com.

Registering on UHCMilitaryWest.com allows you to:

• Verify patient eligibility
• Research covered benefits
• Submit referrals/authorizations
• Check referral/authorization status and medical-review requirements for specific codes
• Check claim status

The public area of the website offers important information and the ability to:

• View the TRICARE Provider Handbook
• Download forms
• Read important updates about the TRICARE program and UnitedHealthcare processes
• Link to important reimbursement information
• View the prior authorization list
• Obtain information about the secure website

Online TRICARE Provider Directory

To make referrals easier, UnitedHealthcare has several search options in the online network TRICARE Provider Directory at UHCMilitaryWest.com > Find a Provider. Users can search by care provider type, location or name.

To confirm that your information in the directory is correct, please find yourself in the TRICARE Provider Directory. If your information needs to be updated, please update your information by submitting a form (UHCMilitaryWest.com > Providers > Find a Form > General > Physician and Provider Demographic Change Submission Form) or by contacting UnitedHealthcare at...
877-988-9378. This will allow TRICARE beneficiaries to view your practice, facility, or services in the Provider Directory and will help ensure accurate information for referral and claims management.

Not all TRICARE network care providers are listed in the directory. Urgent care physicians, and some other hospital-based providers may not be listed. Non-network providers are not listed in the online TRICARE Provider Directory. However, there is a link available on the directory which allows the user to search for non-network providers. Non-network providers with demographic changes (for instance, tax ID number, physical location, contact information or claims payment address) should call 877-988-9378 and follow the prompts.

Information in the TRICARE Provider Directory is subject to change without notice. Before beneficiaries choose a network provider, they are encouraged to call and confirm the address and the availability of new-patient appointments.

UnitedHealthcare’s Interactive Voice Response System (IVR)
When you call 877-988-9378, UnitedHealthcare offers an IVR system available 24 hours a day to assist providers with routine questions. The IVR system uses natural speech recognition to understand words, numbers and phrases.

Follow the greeting and prompts to get quick information and accurate answers on many topics, such as verifying beneficiary eligibility and checking the status of claims, referrals and authorizations. You can navigate through the IVR system to speak to customer service staff from 7:00 a.m. to 7:00 p.m. local time, Monday through Friday.

Important Provider Information
Contracted TRICARE providers are obligated to abide by the rules, procedures, policies, and program requirements as specified in this Handbook, which is a summary of the TRICARE regulations and manual requirements related to the program.

TRICARE Policy Resources
The statutes governing the TRICARE Program are found in Chapter 55 of Title 10 of the United States Code of Federal Regulations and Title 32, part 1099 of the United States Code of Federal Regulations (CFR).

The Department of Defense (DoD), through DHA, directs UnitedHealthcare on how to administer the TRICARE program. This direction comes through modifications to the CFR. Additionally, the TRICARE Operations Manual, TRICARE Policy Manual, and TRICARE Reimbursement Manual are updated continually to reflect changes in the CFR. Depending on the complexity of the law and federal funding, it may take a year or more before direction from the DoD is given through DHA, and UnitedHealthcare can begin administration of the new policy.

Social Security Number Reduction Plan
In response to the growing need to protect beneficiaries’ identification (ID) information, the DoD is removing Social Security numbers (SSNs) from DoD ID cards. SSNs are being replaced with 10-digit DoD ID numbers. If a beneficiary has DoD benefits, he or she will also have a DoD Benefits Number (DBN) printed on the card. This is a unique number that is required in order to align beneficiaries’ records with their treatments. The new DBN is above the bar code on the back of the uniformed services ID card. Although SSNs are being removed from ID cards, TRICARE continues to base all operations (e.g., eligibility verification, claims submission, appeals) on the sponsor’s SSN. You may ask a TRICARE beneficiary to provide the sponsor’s SSN verbally or on other standard documentation required by your practice or facility.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
HIPAA was enacted on August 21, 1996, to improve portability of health insurance coverage and to simplify health care billing through the development of electronic data interchange and to combat waste, fraud, and abuse. The U.S. Department of Health and Human Services (HHS) developed regulations implementing HIPAA’s administrative simplification provisions, specifically, Transactions and Code Sets Rules, and rules on Employer Identifier and National Provider Identifier (NPI) numbers.

The impending use of electronic data caused privacy concerns among the public. Therefore, Congress included a mandate in HIPAA to develop privacy protections. In the absence of federal legislation, HHS published regulations developing privacy protections. These rules became effective April 14, 2003, and additional regulations on security of electronic health information took effect in 2005. Congress subsequently enacted significant amendments to these privacy and security rules in the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was part of the 2009 stimulus legislation.
The DoD MHS generally adheres to the HHS rules implementing administrative simplification, including privacy and security. The MHS also complies with the 1974 Privacy Act. For more information on MHS privacy procedures, see DoD Regulations 5400.1R, 6025.18-R, and 8580.02-R, all of which are available at dtic.mil/whs/directives/corres/pub1.html. Additional information is available on the DHA Privacy Office website at tricare.mil/pra/

For more TRICARE-specific information on HIPAA, refer to the TRICARE Operations Manual, Chapter 1, Section 5 and Chapter 19 at manuals.tricare.osd.mil.

TRICARE health plans, MTFs, providers, and their contractors and subcontractors are generally required to comply with the DoD's rules and the HIPAA administrative simplification rules, as amended by the HITECH Act, as applicable. The HIPAA requirements set forth in this Handbook are applicable to MHS providers.

**HIPAA Privacy Rule**

The following is only a brief introduction to selected aspects of the HIPAA Privacy Rule. TRICARE health care providers should consult the more detailed guidance materials available from the DHA Privacy Office at tricare.mil/tma/privacy.

The HIPAA Privacy Rule generally requires individual health care providers, institutional providers such as MTFs, their workforce members, and their contractors to use and disclose protected health information (PHI) only as permitted or required by the HIPAA Privacy Rule. PHI is individually identifiable health information, which includes demographic and payment information created and obtained by providers who deliver health services to patients. Examples of PHI include medical-record data (documentation of symptoms, examination and test results, diagnoses, treatments, and plans for future care or treatment) and billing documents.

The HIPAA Privacy Rule permits care providers to use and disclose PHI without a patient's written authorization for purposes of treatment, payment, and health care operations. Health care operations include activities such as quality assessment, quality improvement, outcome evaluation, protocol and clinical-guidelines development, training programs, credentialing, medical review, legal services, and insurance.

The HIPAA Privacy Rule also permits uses and disclosures of PHI without a patient’s authorization in various situations not involving treatment, payment, and health care operations. These situations include, for example, public health activities, health oversight activities, judicial and administrative proceedings, decedent situations, and research. 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 active duty service members (ADSMs) to their military commanders to determine fitness for duty or certain other purposes. Similarly, PHI of service members separating from the armed forces may be disclosed to the U.S. Department of Veterans Affairs (VA).

PHI may be used or disclosed for other purposes only with written authorization of the patient or the patient’s personal representative. The authorization form must satisfy specific requirements under the HIPAA Privacy Rule.

Patients must be given the opportunity to agree or object to disclosure of their PHI in facility directories and disclosures to persons involved in their care. Written authorizations are not required in these cases.

Under the HIPAA Privacy Rule, beneficiaries have the right to:

- Receive a copy of the Military Health System Notice of Privacy Practices
- Request access to PHI
- Request amendment of PHI
- Request an accounting of PHI disclosures
- Request restrictions on, or confidential communications of, PHI use and disclosure
- File a complaint regarding any privacy infractions

Providers must also establish administrative, physical, and technical safeguards for PHI. Moreover, actual or possible unauthorized use or disclosure of PHI (a breach) may require notifying affected individuals and reporting to DHA and other government entities. For more information on responding to privacy breaches, visit tricare.mil/tma/privacy.

The Military Health System Notice of Privacy Practices informs beneficiaries about their rights regarding PHI and explains how PHI may be used or disclosed, who can access PHI, and how PHI is protected. The notice is published in 11 languages. Braille
and audio versions are also available. Visit tricare.mil/privacy to download copies of the Military Health System Notice of Privacy Practices for you and your staff.

Privacy officers are available for every MTF. They serve as beneficiary advocates for privacy issues and respond to beneficiary inquiries about PHI and privacy rights. More information about privacy practices and other HIPAA requirements is available at tricare.mil/privacy. Beneficiaries and providers may also email inquiries to privacymail@DHA.osd.mil.

**Release of Medical Records and Other Protected Health Information (PHI)**

PHI may be released to the individual who is the subject of the PHI and, unless contraindicated, to that individual’s personal representative. Personal representatives include parents of unemancipated minors, guardians, and other persons who have legal authority to act on behalf of the individual with respect to health care decisions.

Exceptions may include circumstances involving unemancipated minors and applicable state laws, and abuse, neglect, or endangerment situations. Additionally, special care must be taken when PHI includes unusually sensitive medical conditions, such as:

- abortion
- pregnancy
- AIDS
- sexually transmitted diseases
- alcoholism or other substance abuse
- mental health conditions.

UnitedHealthcare representatives must comply with the Privacy Act of 1974 and HIPAA Privacy Rules when TRICARE beneficiaries call regarding claims and other patient benefit information.

If a person requests information on behalf of a TRICARE beneficiary, UnitedHealthcare may not disclose information until the proper legal paperwork is received. UnitedHealthcare will not disclose information to a person who:

- Calls on behalf of a spouse or adult child (as defined under applicable state law) who has not submitted an Authorization to Disclose form
- Is caring for a child whose deployed active duty sponsor has not submitted power of attorney documentation to allow disclosure of the child’s medical information
- Is the spouse of a deployed ADSM who has not provided a valid power of attorney or other appropriate documentation to allow disclosure of the ADSM’s medical information
- Is not shown to be the parent or other personal representative of a minor child whose PHI would be disclosed
- Is the spouse or family member of a deceased sponsor, but legal representative appointment documentation for the estate has not been submitted to UnitedHealthcare. (If there is no legal representative for the estate, the individual seeking the PHI must furnish a written statement of his or her relationship to the deceased and the provider should confer with legal counsel.)

To download the Authorization to Disclose form, go to UHCMilitaryWest.com > Beneficiary > Find A Form > Privacy Release Forms.

If you have additional questions about the HIPAA Privacy Rule and TRICARE, visit the DHA Privacy and Civil Liberties Office website at tricare.mil/tmaprivacy or the HHS Health Information Privacy website at hhs.gov/ocr/privacy.

**HIPAA Security Rule**

The HIPAA Security Rule requires administrative, physical, and technical safeguards to assure the confidentiality, integrity, and availability of PHI in electronic form. Specific safeguards are not prescribed. Instead, the HIPAA Security Rule establishes general standards and associated implementation specifications. The implementation standards are either “required” (standards that must be implemented) or “addressable” (standards that must be assessed and either implemented if reasonable and appropriate, or otherwise addressed with reasonable alternative measures and documentation of the assessment).

TRICARE providers are expected to adhere to industry standards and regulatory developments on data-security protection.
Additionally, providers should consult the guidance materials available on the DHA Privacy and Civil Liberties Office website at tricare.mil/tma/privacy, which includes information on new regulations under the HITECH Act and any other legislative initiatives affecting data security.

**HIPAA Transactions and Code Sets Rule**

The HIPAA Transactions and Code Sets Rule implemented electronic standards for certain administrative and financial health care transactions. As required by the HIPAA Standard Transactions and Code Sets Rule, the MHS and TRICARE apply HIPAA standards for electronic business functions.

For more information, visit the HIPAA and TRICARE Transaction and Code Sets website at tricare.mil/tma/hipaa/transactions.

HHS has published Final Rules to adopt updated versions of HIPAA Electronic Transactions and Code Sets. These Final Rules require compliance with X12 Version 5010 and NCPDP D.0 transactions no later than January 1, 2012, and in compliance with ICD-10-CM and ICD-10-PCS.

**HIPAA Employer Identifier Number (EIN)**

The National Employer Identifier Final Rule requires health care providers, plans and clearinghouses to accept and transmit employer identification numbers (EINs) in electronic health care transactions, when applicable. HIPAA defines employers as health insurance sponsors for their employees. The standard selected for the national employer identifier is the EIN issued by the Internal Revenue Service (IRS). The EIN appears on an employee’s IRS Form W-2 Wage and Tax Statement and is used to identify the employer in standard electronic health care transactions.

### HIPAA Electronic Transactions

<table>
<thead>
<tr>
<th>Transaction No.</th>
<th>Transaction Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>X12N 270/271</td>
<td>Eligibility/Benefit Inquiry and Response</td>
</tr>
<tr>
<td>X12N 278</td>
<td>Referral Certification and Authorization</td>
</tr>
<tr>
<td>X12N 837</td>
<td>Claims (Institutional, Professional, and Dental) and Coordination of Benefits (COB)</td>
</tr>
<tr>
<td>X12N 276/277</td>
<td>Claim Status Request and Response</td>
</tr>
<tr>
<td>X12N 834</td>
<td>Claim Payment and Remittance Advice</td>
</tr>
<tr>
<td>X12N 820</td>
<td>Enrollment/Disenrollment in a Health Plan</td>
</tr>
<tr>
<td>NCPDP Telecom Standard</td>
<td>Retail Pharmacy Drug Claims, COB, Referral Certification and Authorization, Eligibility Inquiry and Response</td>
</tr>
<tr>
<td>NCPDP Batch Standard</td>
<td>Retail Pharmacy Drug Claims, COB, Referral Certification and Authorization, Eligibility Inquiry and Response</td>
</tr>
</tbody>
</table>

**HIPAA National Provider Identifier (NPI)**

The HIPAA NPI Final Rule, published in the Federal Register, establishes the NPI as the standard unique identifier for health care providers. An NPI is a 10-digit number used to identify a health care provider in all HIPAA standard electronic transactions. NPIs do not contain intelligence about providers. All entities defined as “health care providers” are eligible for NPIs. However, providers defined under HIPAA as “covered entities” are required to obtain and use NPIs. A covered entity is a provider, health plan, or clearinghouse that conducts electronic health care transactions.

Health care provider NPI enumeration (i.e., assignment of NPIs to providers) and NPI-associated data maintenance are conducted through the National Plan and Provider Enumeration System (NPPES). The NPPE is the central system for identifying and uniquely enumerating health care providers at the national level. For enumeration purposes, there are two categories of health care providers. Entity Type 1 is for individuals, such as physicians, nurses, dentists, pharmacists and physical therapists. Entity Type 2 is for organizations, such as hospitals, home health agencies, clinics, nursing homes, laboratories and MTFs. The NPI is meant to be a lasting identifier and is not replaced due to changes in a health care provider’s name, address, ownership, health plan membership, or Healthcare Provider Taxonomy classification.

TRICARE providers should already have NPIs. If you do not have an NPI, complete the online NPPES application at https://nppes.cms.hhs.gov or download a paper application of the National Provider Identifier (NPI) Application/Update Form at cms.gov > Regulations-and-Guidance > HIPAA Administrative Simplification > National Provider Identifier Standard (NPI). You may also request an application from the NPI Enumerator in one of the ways listed in Figure 3.2.
NPI Enumerator Contact Information  

| Phone         | 800-465-3203  
|              | 800-692-2326 (TTY)  
| Email        | customerservice@npienumerator.com  
| Mail         | NPI Enumerator  
|              | P.O. Box 6059  
|              | Fargo, ND 58108-6059  

For more information about NPIs, visit the Centers for Medicare and Medicaid Services website at cms.hhs.gov/NationalProvIdentStand. For TRICARE-specific information, visit myTRICARE.com > Billing Information.

TRICARE Provider Types

TRICARE defines a provider as a person, business, or institution that renders health care services. For example, doctors are individual providers, hospitals are institutional providers, and ambulance companies are corporate providers. There are many other provider types. A provider must be authorized under TRICARE regulations and certified by UnitedHealthcare. Figure 3.3 on the following page provides an overview of TRICARE provider types.

Note: Active duty service members (ADSMs) and civilian employees of the federal government who are health care providers are generally not authorized to be TRICARE providers in civilian facilities. Only TRICARE-certified civilian providers may receive reimbursement from TRICARE.

Military Treatment Facilities

An MTF is a medical facility (e.g., hospital, clinic) owned and operated by the uniformed services—usually located on or near a military base. To locate MTFs in the West Region, visit the MTF Locator at tricare.mil/mtf.

Military Treatment Facility Right of First Refusal (ROFR)

Provided the MTF is able to render the service requested, MTFs are given the ROFR for TRICARE Prime beneficiaries residing in a TRICARE Prime Service Area (PSA) for inpatient admission referrals, specialty appointments, and procedures requiring prior authorization. The MTF staff will review the referral to determine if they have the specialty capability and an available specialty care appointment within TRICARE access standards. If the MTF accepts the care, the Prime beneficiary must obtain these services at the MTF. If the service is not available at the MTF within the appropriate access standards, the beneficiary is referred to a TRICARE network provider.

Note: ROFR does not apply to TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPR ADFMs) enrollees seeking care at MTFs.

When submitting a referral request for review, it is important to include the following:

1. Please ensure you provide “complete” patient information:
   a. Full name of patient (not sponsor)
   b. Sponsor’s SSN, DBN or DoD ID number
   c. Current mailing address to include home ZIP code (for ROFR consideration)
   d. Patient phone (to permit MTF to communicate directly with the patient).
2. Please include a “provisional/suspected” diagnosis on cover sheet
3. Please specify in the first line what exactly is requested/needed in the referral. For example: “MRI of Right Shoulder” or “Neurology Consultation of back.” Then add history, background, etc.

Failure to provide complete information can result in delays when the referral is sent to the MTF for ROFR review. Following these guidelines will assist the MTF in completing the review in a timely manner.
TRICARE Provider Types

TRICARE-Authorized Providers

- TRICARE-authorized providers meet state licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (laboratory and radiology providers), and pharmacies. Beneficiaries are responsible for the full cost of care if they see providers who are not TRICARE-authorized.
- There are two types of TRICARE-authorized providers: network and non-network.

<table>
<thead>
<tr>
<th>Network Providers</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Regional contractors have established networks, even in areas far from military treatment facilities.</td>
<td>- Non-network providers do not have signed agreements with UnitedHealthcare and, therefore, are considered “out-of-network.”</td>
</tr>
</tbody>
</table>
| - TRICARE network providers:  
  › Have signed agreements with UnitedHealthcare to provide care.  
  › Agree to file claims and handle other paperwork for TRICARE beneficiaries.  
  › Are required to have malpractice insurance.  
  › Agree to accept the negotiated payment rate (less any copayments, cost-shares, or deductibles payable by the TRICARE beneficiary) as payment in full. | - There are two types of non-network providers: participating and nonparticipating. |

<table>
<thead>
<tr>
<th>Participating</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>- May choose to participate on a claim-by-claim basis.</td>
<td>- Do not agree to accept the TRICARE-allowable charge or file claims for TRICARE beneficiaries.</td>
</tr>
<tr>
<td>- Agree to accept payment directly from TRICARE and accept the TRICARE-allowable charge as payment in full for their services.</td>
<td>- Have the legal right to charge beneficiaries up to 15 percent above the TRICARE-allowable charge for services.</td>
</tr>
</tbody>
</table>

Corporate Services Provider Class

The Corporate Services Provider 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 specific provider types in this category include:

- Cardiac rehabilitation clinics
- Comprehensive outpatient rehabilitation facilities
- Diabetic outpatient self-management education programs  
  (American Diabetes Association® recognition required)
- Freestanding bone-marrow transplant centers
- Freestanding kidney-dialysis centers
- Freestanding magnetic resonance imaging centers
- Freestanding radiology centers
- Freestanding sleep disorder diagnostic centers
- Home health agencies
- Home infusion (Accreditation Commission for Health Care accreditation required)
- Independent physiological laboratories
- Pain-management clinics
- Rehabilitation clinics
- Radiation-therapy programs

Network corporate services providers are certified during the credentialing process. Non-network corporate services providers must apply to become TRICARE-authorized. Qualified non-network providers may download the Application Form For Corporate Services Providers by visiting UHCMilitaryWest.com > Providers > Find A Form > Certification.

The Department of Veterans Affairs (VA)

TRICARE network provider information is given to the VA and to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). VA has the right to directly contact a provider and request care on a case-by-case basis for
Provider Certification and Credentialing

Certification
At a minimum, TRICARE providers must be certified. PGBA conducts the certification process, which includes assigning a TRICARE ID number to the provider. Being TRICARE-certified allows accurate 1099 tax form reporting to the IRS. Providers who are TRICARE certified but have not signed a contract with UnitedHealthcare Military & Veterans, are considered non-network providers. Refer to UHCMilitaryWest.com > Providers > Out of Network Providers > FAQs for information on how to become certified. Behavioral health care providers, skilled nursing facilities, providers in Alaska, and providers who are not Medicare-certified must complete and submit certification forms in order for PGBA to process their claims. To download certification forms, visit myTRICARE.com > Find a Form > Provider Certification.

Credentialing
In addition to becoming certified, providers interested in signing a contract and becoming a member of the TRICARE network need to be credentialed by UnitedHealthcare. The credentialing process involves obtaining primary-source verification of the provider’s education, board certification, license, professional background, malpractice history and other pertinent data. A provider who is certified, credentialed and has signed a contract is considered to be a network provider following the final notification of contract execution by UnitedHealthcare.

Note: It is important that care providers wait for final notification of contract execution from UnitedHealthcare before providing care to TRICARE beneficiaries as network providers.

Conflict of Interest
Federal law (5 U.S.C. 5536) prohibits medical personnel who are ADSMs or civilian employees of the government to receive compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary.

Claims for TRICARE benefits will be denied in any situation where either a uniformed service member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selection basis.

This means that MTF providers and providers who are activated National Guard and Reserve members may not self-refer from an MTF or a federal government clinic to a civilian practice. Additionally, they may not bill TRICARE for services provided to any TRICARE beneficiary. For providers who are National Guard and Reserve members, this is effective only when the provider is activated, not when they receive their orders.

When a National Guard and Reserve member who is a network provider is activated, he or she may remain a network provider. However, during the activation period, the provider’s information will not be displayed in the online TRICARE Provider Directory and in the referral and authorization system until the provider returns to civilian status. It is very important that the provider notifies UnitedHealthcare once he or she receives orders and upon return. For more information, please contact UnitedHealthcare at 877-988-9378.

Provider Responsibilities
When a provider signs a TRICARE Provider Agreement, the provider agrees to adhere to all contract requirements, as well as all applicable TRICARE program requirements. The following is a sample of network provider requirements, some which may be more fully detailed in the provider’s contract:

• Provider agrees to accept the reimbursement rates (less the amount of any copayments, cost-shares, or deductibles payable by the TRICARE beneficiary) as the only payment expected from UnitedHealthcare and TRICARE beneficiaries for covered services and for all services paid for by the TRICARE program. Please refer to the Balance Billing and Hold-Harmless sections for more detailed information.
• Provider agrees not to require payment from a TRICARE beneficiary for any excluded or excludable service the
TRICARE beneficiary received unless the TRICARE beneficiary has been properly informed that the services are excludable and has agreed, in writing, in advance of receiving the services, to pay for such services. Any waivers must be specific as to the details of the excluded or non-covered service. See Waiver of Non-Covered Services later in this section.

- Providers agree not to charge a beneficiary for the following:
  - Services for which the service is already paid for
  - Services for which the provider is entitled to payment from TRICARE
  - Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements
  - Services not medically necessary and appropriate for the clinical management of the presenting illness, injury, disorder or maternity
  - Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review
  - Services rendered during a period in which the provider was not in compliance with one or more conditions of authorization

- Provider agrees to submit all claims for covered services on behalf of TRICARE beneficiaries and ADSMs.
- Provider must participate in Medicare (accept assignment) and submit claims on behalf of all TRICARE and Medicare beneficiaries.
- Provider agrees to comply with all policies and procedures set forth in this Handbook and in the TRICARE manuals, including, without limitation, credentialing, peer review, referrals, utilization review/management, and quality-assurance programs and procedures established by UnitedHealthcare or TRICARE, including submission of information concerning provider and compliance with referral and authorization requirements, concurrent reviews, retrospective reviews, and discharge planning for inpatient admissions.
- Provider understands that the preferred method of submitting referral and authorization requests is by utilizing the online submission method on UHCMilitaryWest.com.
- If a provider delivers behavioral health care services, and the TRICARE beneficiary authorizes release of the information, the provider should submit a copy of the record of the treatment provided to the TRICARE beneficiary’s primary care manager (PCM).
- Provider and staff will participate in TRICARE education programs to obtain an understanding of TRICARE requirements.
- Provider understands and agrees that all covered services provided to TRICARE Prime beneficiaries, except emergency services, clinical preventive services, and the first eight self-referred routine outpatient mental health care visits for covered benefits from a network provider per fiscal year (FY, Oct. 1–Sept. 30), must be referred from the PCM to a network provider or MTF provider, and authorized by the applicable designee of UnitedHealthcare.
- Provider acknowledges and understands the MTF has the ROFR to provide medical services to TRICARE Prime beneficiaries who are referred for any services by their PCMs or other civilian providers.
- Provider agrees to comply with all final HIPAA ASC X12N Transactions and Code Sets standards as promulgated by the secretary of HHS.
- Provider will include his or her NPI when submitting claims for health care services.
- Provider will cooperate with all UnitedHealthcare requests for information, documents or discussions for purposes of concurrent review and discharge planning including, but not limited to: primary and secondary diagnosis, clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information via access to Electronic Medical Records (EMR).
• Provider will cooperate with all UnitedHealthcare requests from the inpatient care management team and/or medical director to engage with providers and beneficiaries telephonically.

• Provider must return/respond to inquiries from our inpatient care management team and/or medical director by providing complete clinical information and/or documents as required within four hours if our request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day, if the request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).

• Provider will furnish medical records and other documentation in accordance with applicable provisions of the Handbook, UnitedHealthcare’s utilization management plan or other policies, the provider’s contract, and TRICARE requirements. (For example: Specialists and facilities must submit consultation reports, discharge summaries, operative reports, therapy reports, or imaging studies to the beneficiary’s PCM within 10 working days. If clinically warranted, reports regarding additional procedures or skilled therapies conducted during follow-up visits should also be forwarded. A final report is required to the referring provider within 10 business days after the last visit. Refer to “Consult Report Tracking” in the Health Care Management and Administration section of this Handbook for additional information.)

• Provider agrees to submit at least one email address to UnitedHealthcare for purposes of communicating important TRICARE updates.

• Provider’s liability insurance must be, at a minimum, of the types and in the amounts set forth in the applicable Liability Insurance Requirements Table. Such insurance may be provided on either an occurrence basis or claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail) for a period of not less than three years after the end of the contract term with UnitedHealthcare must also be provided, or as long as standard practice in the locality or as may be required by local law or ordinance.

• Provider agrees to indemnify, defend and hold harmless the United States Government from any and all claims, judgments, costs, liabilities, damages and expenses, including attorneys’ fees, arising from any acts or omissions of the provider.

• Provider agrees to accept the negotiated payment rates for any person whose care is reimbursable by the DoD and not to balance bill the TRICARE beneficiary. (Refer to the Balance Billing section for more detailed information).

• Provider agrees to cooperate fully with UnitedHealthcare’s utilization and clinical quality management programs.

• Provider agrees to refer TRICARE beneficiaries only to providers with which the referring provider does not have an economic interest (as defined in 32 C.F.R. 199.2).

• Provider agrees to limit services furnished under arrangement to those for which receipt of payment by the TRICARE-authorized provider discharges the payment liability of the beneficiary.

• Provider agrees to being reported to the Department of Veterans Affairs (VA) as a TRICARE network provider. With regard to non-institutional network providers, the provider is asked to accept requests from the VA to provide care to veterans. The VA has the right to directly contact a provider and request the delivery of care to veteran patients on a case by case basis. An individual, home health care, free-standing laboratory, and free-standing radiology network provider who accepts VA patients is required to serve as a participating provider and accept assignment with the VA. If seen by the network provider, any documentation of the care rendered to the VA patient and reimbursement for the care is a matter between the referring VA Medical Center (VAMC) and the provider. The referral and instructions for seeking reimbursement from the VAMC will be provided by the patient at the time of the appointment. Nothing prevents the VA and the provider from establishing a direct contract relationship if the parties so desire.

• Provider agrees to being reported to Civilian Health and Medical Program of the Department of Veterans Administration (CHAMPVA) as a TRICARE network provider. An individual, home health care, free-standing laboratory, and free-standing radiology network provider who accepts CHAMPVA patients is required to serve as a participating provider and accept assignment with the VA. UnitedHealthcare will provide you with CHAMPVA
claims processing instructions on submitting CHAMPVA claims to the VA Health Administration Center for payment.

- All acute-care medical/surgical hospitals in UnitedHealthcare’s TRICARE network are encouraged to become members of the National Disaster Medical System.

- Provider agrees to give prompt written notification of the provider’s employment of an individual who, at any time during the 12 months preceding, was employed in a managerial, accounting, auditing, or similar capacity, by an agency or organization which is responsible, directly or indirectly for decisions regarding DoD payments to the provider.

**Non-Discrimination Policy**

When providing covered services, TRICARE network (contracted) and non-network 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. Providers may read the full TRICARE Non-Discrimination policy by accessing the [TRICARE Operations Manual](#), Chapter 1, Section 5 at manuals.tricare.osd.mil.

**Office and Appointment Access Standards**

By signing a TRICARE contract, network providers are obligated to adhere to all contract requirements. One of the contract requirements is to meet all office and appointment access standards. Those standards are as follows:

- Office wait times for nonemergencies may not exceed 30 minutes, unless the provider is rendering emergency care and the normal schedule is disrupted. If you are running behind schedule, notify your patient of the cause and anticipated length of the delay, and offer to reschedule the appointment.

- PCM/primary care providers must be available by telephone or by appointment 24 hours a day, 7 days a week to provide timely evaluation of the beneficiary’s health care needs. If the PCM/primary care provider is not available, the covering PCM/primary care provider is subject to UnitedHealthcare’s credentialing and peer-review procedures.

- Wait times for appointments for acute illnesses may not exceed one day (24 hours).

- Wait times for routine appointments may not exceed one week (seven days).

- Wait times for appointments for wellness and specialty visits may not exceed four weeks (28 days).

- Wait times for an urgent care appointment shall generally not exceed 24 hours.

- Facilities and offices must be accessible to persons with disabilities, in accordance with federal and state regulations.

**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, which require beneficiaries to sign agreements to accept financial responsibility for missed appointments. TRICARE does not reimburse beneficiaries for missed appointment fees. TRICARE providers may not submit claims to TRICARE for missed appointments.

**Primary Care Manager’s Role**

TRICARE Prime beneficiaries agree to seek all nonemergency services initially from their PCMs who they selected for primary care services at the time of enrollment. The PCM is an individual provider within a military or a civilian location.

**Note:** TRICARE Prime beneficiaries may not initially seek services from any provider except their PCM, unless they are:

- Using the [TRICARE Prime Point-of-Service Option (POS)](#)
- Seeking emergency care
- Seeking clinical preventive services from a network provider
- Seeking the first eight self-referred routine outpatient mental health care visits for covered benefits from a network provider per FY
Note: ADSMs must always have a referral for care outside of an MTF (unless it is an emergency), including all behavioral health care services. If the ADSM has an assigned civilian PCM under TRICARE Prime or under TRICARE Prime Remote (TPR), all specialty referral and authorization guidelines must be followed.

The PCM’s roles and responsibilities are as follows:

- Primary care services are typically, although not exclusively, provided by internal medicine physicians, family practitioners, pediatricians, general practitioners, obstetricians, gynecologists, physician assistants, or nurse practitioners to the extent consistent with governing state rules and regulations.

- The PCM is responsible for performing primary care services and managing all of the care of his or her TRICARE Prime patients. The PCM must render care for acute illness, minor accidents, and follow-up care for ongoing medical problems.

- When a provider signs a contractual agreement to become a PCM (only applicable in PSAs), the provider must follow TRICARE procedures and requirements for obtaining specialty referrals and prior authorizations for nonemergency inpatient and certain outpatient services. Claims submitted for services rendered without a required prior authorization are subject to a penalty based on the contracted rate.

- In the event that the assigned PCM cannot provide the full range of necessary primary care functions, the PCM must provide support for access to the necessary health care services, as well as any specialty requirements.

- PCMs are required to provide access to care 24 hours a day, seven days a week, including after hours and urgent care services, or arrange for on-call coverage by another provider.

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

  ‣ Routine care—The PCM 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 must contact the PCM within 24 hours of an inpatient admission to support continuity of care.

- PCMs referring patients for specialty care may need to coordinate the referral with UnitedHealthcare. This includes submitting the referral request to UnitedHealthcare and establishing medical necessity, when needed.

- When a PCM refers a TRICARE Prime beneficiary for specialty obstetric care, prior authorization must be obtained for both outpatient and inpatient services.

- The PCM enrollment panel should remain open to TRICARE beneficiaries. However, UnitedHealthcare requests a 30-day advance written notification if the PCM determines that it is necessary to close his or her panel for a period of time.

Emergency Care Responsibilities

Providers are required to notify UnitedHealthcare within 24 hours of a medical admission and up to, but not longer than, 72 hours following an emergency mental health admission. For more information on this requirement, see “Inpatient Admission Notification” in the Health Care Management and Administration section of this Handbook. This notification requirement also applies on weekends. UnitedHealthcare case managers or UnitedHealthcare clinical staff will review the information submitted to determine if authorization is necessary. Except in true emergencies, TRICARE Prime enrollees must have approval from their PCMs or UnitedHealthcare, or the care may not be covered under the TRICARE POS option. Refer to the Emergency Care section of this Handbook for more information on emergency and urgent care services.

Balance Billing

Network providers may only bill TRICARE beneficiaries for applicable deductible, copayment, or cost-sharing amounts, but may not bill for charges that exceed contractually agreed upon payment rates. Because network providers have contractually agreed
to adhere to these provisions, TRICARE beneficiaries will be referred first to a network provider. Any provider who is uncertain about the amount that may be billed to a TRICARE beneficiary may call UnitedHealthcare at 877-988-9378. The beneficiary’s responsibility is reflected on the explanation of benefits (EOB), and the provider’s remittance advice. Non-network providers who accept assignment are limited to collecting the TRICARE-allowable charge. If the billed charge is less than the allowable charge, the billed charge becomes the allowable amount. The balance billing restriction applies only to services covered by TRICARE.

Non-network, nonparticipating providers may collect applicable deductibles and/or cost-shares and copayments and any outstanding amounts up to 15 percent above the TRICARE-allowable charge (shown on the EOB) from a non-Prime beneficiary. If the billed charge is less than the TRICARE-allowable charge, the billed charge is the allowable amount used to process the claim. The balance billing restriction applies only to services covered by TRICARE. TRICARE’s balance billing limit also applies when other health insurance (OHI) is involved. Providers may not bill beneficiaries for administrative expenses, including collection fees, to collect TRICARE amounts. (Also see the TRICARE Prime Point-of-Service Option (POS) section for additional beneficiary options.)

The billing restriction for nonparticipating providers is contained in Section 9011 of the Department of Defense Appropriations Act of 1993 (Public Law 102-396), and became effective on November 1, 1993. The billing limitation is the same as that used by Medicare. For the specific details of this law, refer to 32 CFR 199.14 (j) (1)(C). Non-compliance with these balance billing requirements by any TRICARE provider may affect that provider’s TRICARE and/or Medicare status. Additional information regarding allowable charges is available at tricare.mil. For more information regarding beneficiary costs of using non-network providers, please refer to the TRICARE Prime Point-of-Service Option (POS) section of this Handbook and on tricare.mil.

**Balance Billing and Other Health Insurance (OHI)**

Providers are limited to collecting the amount as described above under “Balance Billing,” regardless of the beneficiary’s OHI financial responsibility. When OHI is involved, the provider may not collect more than his or her billed charges from the primary payer and TRICARE combined (up to the TRICARE maximum allowed amount as outlined above). TRICARE will pay the beneficiary liability unless that amount is more than the TRICARE-allowable charge.

**Informing Beneficiaries about Non-Covered Services**

As part of good business practices, providers need to notify TRICARE beneficiaries when a service is not a TRICARE-covered service. TRICARE has established a specific hold-harmless policy for network providers and recommends that non-network providers also follow a similar process for documenting beneficiary notification.

Network providers cannot bill beneficiaries for non-covered services unless the beneficiary has agreed in advance and in writing to pay for non-covered services. Refer to the Limitations and Exclusions Section for non-covered services.

**Hold-Harmless Policy for Network Providers**

A network provider may not require payment from a TRICARE beneficiary for any non-covered services the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) except as follows:

- If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary, the provider may bill the beneficiary for services provided.
- If the beneficiary was informed that the services were non-covered and he or she agreed in advance to pay for the services, the provider may bill the beneficiary.

TRICARE beneficiaries must be properly informed in advance and in writing of specific services or procedures that are not covered under TRICARE before they are provided. If they choose to be financially responsible for the non-covered services, beneficiaries must sign a waiver agreeing to pay for non-covered services. See Waiver of Non-Covered Services later in this section for details.

An agreement to pay must be evidenced by written records, examples of which include:

- Provider notes demonstrating that, before receiving services, the beneficiary was informed that the services were non-covered and the beneficiary agreed to pay for them.
- A statement or letter written by the beneficiary prior to receipt of the services, acknowledging the services were non-covered and agreeing to pay for them.
However, if the network provider does not obtain a legal, signed waiver before the non-covered services are provided, and the care is not authorized by UnitedHealthcare, the provider is expected to accept full financial liability for the cost of non-covered services rendered without authorization by UnitedHealthcare or the beneficiary’s written agreement to pay for non-covered services.

For the beneficiary to be considered fully informed, TRICARE regulations require that:

- The agreement is documented prior to the specific non-covered services being rendered
- The agreement is in writing
- The specific treatment and date(s), estimated cost of service, and billed amounts are documented

General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or not allowable.

A general statement of financial liability does not satisfy this requirement.

**Waiver of Non-Covered Services**

A network provider may utilize the TRICARE Beneficiary Liability Form (Waiver of Non-Covered Services) when the beneficiary is properly informed, in advance, that TRICARE does not cover a particular service and he or she agrees in writing to be financially responsible. The Waiver of Non-Covered Services form is available online at UHCMilitaryWest.com > Providers > Find a Form > General. This waiver may not be used for TRICARE services that are not payable for other than benefit reasons (e.g., ClaimCheck® edits, administrative expenses, the difference between the allowed amount and paid amount). Waivers of non-covered services must be in writing and include the following:

- Indication that the rendering provider is a network provider
- Reference to the specific non-covered service or procedure
- Notice that the service or procedure is not covered
- Written agreement to be financially responsible for non-covered services prior to receiving those services
- The beneficiary’s signature
- The date signed

Providers must maintain copies of the waiver in their offices. See the Medical Coverage section of this Handbook for a summary of TRICARE-covered and non-covered services and benefits.

**Hold-Harmless Policy for Non-Network Providers**

Although non-network providers are not obligated to use a TRICARE-specific form to document the payment agreement, it is important that non-network providers inform beneficiaries that they will be responsible for paying for non-covered services.

A written document listing the specific service(s) and cost(s) of the non-covered services identifying this agreement is recommended.

**“An Important Message from TRICARE”**

Inpatient facilities are required to provide each TRICARE beneficiary with a copy of the document “An Important Message from TRICARE.” This document details the beneficiary’s rights and obligations upon hospital admission. The complete signed document must be kept in the beneficiary’s file. A new document is needed for each admission. If PGBA or UnitedHealthcare requests a copy of the beneficiary’s medical record, a copy of this entire document, signed by the beneficiary, must be included in the file. “An Important Message from TRICARE” is located at UHCMilitaryWest.com > Providers > Find a Form > General.

It is important that beneficiaries be given the correct document that lists contact information for UnitedHealthcare Military & Veterans, the West Region contractor. Medicare’s similar document or another TRICARE contractor’s document cannot be substituted for TRICARE West Region beneficiaries.
Updating Provider Information

It is important for providers to report any outdated or incorrect demographic information as soon as possible. This enables UnitedHealthcare to provide accurate information to TRICARE beneficiaries and help to ensure that your claims are appropriately paid and payments are mailed to the correct address. It is also important to keep your demographics updated in the directory to note whether you are accepting new patients. We understand this information changes frequently, but keeping your information accurate helps to reduce the workload of your staff. It may also reduce the amount of calls and inquiries your staff receives from beneficiaries who may be frustrated trying to identify available providers in the TRICARE network.

To help make referrals easier, UnitedHealthcare has several search options in the online network TRICARE Provider Directory at UHCMilitaryWest.com > Find a Provider. Users can search by care provider type, location or name.

To confirm that your information in the directory is correct, please find yourself in the TRICARE Provider Directory. If your information needs to be updated, please update your information by submitting a form (UHCMilitaryWest.com > Providers > Find a Form > General > Physician and Provider Demographic Change Submission Form) or by contacting UnitedHealthcare at 877-988-9378. This will allow TRICARE beneficiaries to view your practice, facility, or services in the Provider Directory and will help ensure accurate information for referral and claims management.

Not all TRICARE network care providers are listed in the directory. Urgent care physicians, and some other hospital-based providers may not be listed. Non-network providers are not listed in the online TRICARE Provider Directory. However, there is a link available on the directory which allows the user to search for non-network providers. Non-network providers with demographic changes (for instance, tax ID number, physical location, contact information or claims payment address) should call 877-988-9378 and follow the prompts.

Information in the TRICARE Provider Directory is subject to change without notice. Before beneficiaries choose a network provider, they are encouraged to call and confirm the address and the availability of new-patient appointments.

Beneficiary Expectations

According to the DoD, all TRICARE beneficiaries should expect the following:

- **Get information:** Beneficiaries should expect to receive accurate, easy-to-understand information from written materials, presentations, and TRICARE representatives to help them make informed decisions about TRICARE programs, medical professionals, and facilities.

- **Choose providers and plans:** Beneficiaries should expect a choice of health care providers that is sufficient to provide access to appropriate high-quality health care.

- **Emergency care:** Beneficiaries should expect to access medically necessary and appropriate emergency health care services as is reasonably available when and where the need arises.

- **Participate in treatment:** Beneficiaries should expect to receive and review information about the diagnosis, treatment, and progress of their conditions, and to participate fully in all decisions related to their health care, or if unable to do so for him or herself, to be represented by family members or other duly appointed representatives.

- **Respect and nondiscrimination:** Beneficiaries should expect to receive considerate, respectful care from all members of the health care system without discrimination based on race, color, national origin, or any other basis recognized in applicable law or regulations.

- **Confidentiality of health information:** Beneficiaries should expect to communicate with health care providers in confidence and to have the confidentiality of their health care information protected to the extent permitted by law. They also should expect to review, copy and request amendments to their medical records.

- **Complaints and appeals:** Beneficiaries should expect a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them.
TRICARE Eligibility

TRICARE is available worldwide to eligible beneficiaries, including ADSMs and their family members, retired service members and their dependents, National Guard and Reserve members and their families, survivors, certain former spouses, and others, from any of the seven uniformed services: U.S. Army, U.S. Navy, U.S. Air Force, Marine Corps, U.S. Coast Guard, the Commissioned Corps of the U.S. Public Health Service, and the Commissioned Corps of the National Oceanic and Atmospheric Administration.

All beneficiaries must register in the Defense Enrollment Eligibility Reporting System (DEERS) to be eligible for TRICARE. Beneficiaries may verify their eligibility in DEERS by calling 800-538-9552. Providers, when registered, may check patient eligibility at UHCMilitaryWest.com. Providers may not contact DEERS directly due to the Privacy Act of 1974 (Title 5, United States Code, Section 552a).

How to Verify Eligibility

There are several ID and enrollment cards with which providers should be familiar in order to verify a patient’s eligibility for TRICARE. Providers must confirm patients have valid uniformed services ID cards, Common Access Cards (CACs), or authorization Letters of Eligibility (LOE). Be sure to check expiration dates and make copies of both sides of ID cards for your files. See “Copying ID Cards” later in this section.

An ID or CAC card alone is not sufficient to prove TRICARE eligibility. Providers must verify the current eligibility status of the card bearer through UHCMilitaryWest.com (once registered), or by calling 877-988-9378. When verifying eligibility, be sure to use the sponsor’s SSN or DBN.

Be aware of the difference between DoD Number and the DoD Benefits Number (DBN). The location is different. The DoD Number (on the front of the card) should not be used. The DBN is the correct number, and is found on the back of the military ID card.

UHCMilitaryWest.com will allow registered users to verify eligibility with either an SSN or the first nine digits of the DBN. Providers using EDI 270/271 can verify eligibility using an SSN or DBN. UnitedHealthcare’s IVR system can verify the sponsor’s SSN and the DBN. If you are verifying online, retain a printout of the eligibility verification screen for your files.

Note: The DoD is removing SSNs from ID cards. Refer to the “Social Security Number Reduction Plan” in the Important Provider Information section of this Handbook for more information.

Identification Cards

Common Access Card (CAC)

Most ADSMs and drilling National Guard and Reserve members now carry the Common Access Card (CAC). The CAC replaced the uniformed services ID card discussed later in this section. Although CACs are valid uniformed services ID cards, they do not, on their own, prove TRICARE eligibility. The card bearer’s eligibility must be verified as described earlier in this section.

Uniformed Services ID Card

The uniformed services ID card is credit-card sized and incorporates a digital photographic image of the bearer, bar codes containing pertinent machine-readable data, and printed identification and entitlement information. The beneficiary category determines the ID card’s color:

- **Tan:** Dependents of active duty and retired service members, 100 percent VA Disabled Veterans and their dependents, as well as Transitional Assistance Management Program (TAMP) beneficiaries.
• **Red:** Retired Reservists and dependents of Reserve Components

• **Blue:** Retired members of the U.S. Armed Forces

• **Green:** Active duty military (no longer used, replaced by CAC card – see previous section)

These boxes on the ID card contain useful information for the provider and the beneficiary:

- **SSN, sponsor SSN (or last 4 digits of SSN), DBN, or sponsor DBN:** Providers may use the SSN or DBN when verifying the card bearer’s TRICARE eligibility.

- **Expiration date:** Check the expiration date. It should read “INDEF” (i.e., indefinite) for retirees. If expired, the beneficiary must immediately update his or her information in DEERS and get a new card.

- **Civilian:** Check the back of the ID card to verify eligibility for TRICARE civilian care. The center section should read “YES” under the box titled, “CIVILIAN.” If a beneficiary using TRICARE For Life (TFL) has an ID card that reads “NO” in this block, they are still eligible to use TFL if they have Medicare Part A and Medicare Part B coverage.

**Note:** Eligibility may also be verified by a valid photo ID of the dependent when accompanied by a copy of the sponsor’s activation orders when activated for 31 consecutive days or more.

Beneficiaries under age 10 are not routinely issued ID cards, so the parent’s proof of eligibility may serve as proof of eligibility for the child. Children of single parents may be issued their own ID card regardless of age. If someone other than the sponsor or parent takes a child to a provider, the child should have their own ID card.

**ID Cards for Family Members Age 75 and Older**

All eligible family members and survivors of deceased uniformed services members who are age 75 and older will be issued permanent ID cards. Prior to September 2005, only retired uniformed services members were issued permanent ID cards.

**Copying ID Cards**

Military personnel and their family members may express concern about having their uniformed services ID cards photocopied, perhaps because they have always been instructed never to lose or allow someone to use their cards. These instructions are designed to prevent identity theft and safeguard against someone impersonating U.S. military personnel and compromising security.

Although some TRICARE beneficiaries may believe that it is illegal to copy ID cards, it is, in fact, legal to copy uniformed services ID cards for authorized purposes (i.e., obtaining health care).* The legitimate cardholder may allow his or her military or uniformed services ID card to be photocopied to facilitate medical care eligibility determination and documentation, check cashing, or the

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*Title 18, United States Code, Section 701 prohibits photographing or possessing uniformed services ID cards in an unauthorized manner. Unauthorized use would exist only if the bearer uses the card in a manner that would enable him or her to obtain benefits, privileges, or access to which he or she is not entitled.
administration of other military-related benefits. It is both allowable and advisable for providers to copy a beneficiary's ID card to facilitate eligibility verification and for the purpose of rendering needed health care services. DoD recommends that providers copy both sides of the ID cards and retain copies for future reference.

**Important Notes about Eligibility**

ADSMs and active duty family members (ADFMs) lose TRICARE eligibility at midnight on the day the active duty sponsor is separated from service, unless they are eligible for other TRICARE coverage, the Transitional Assistance Management Program (TAMP), Continued Health Care Benefit Program (CHCBP) coverage, or the sponsor is transitioning to retired status. Refer to the [TRICARE Program Options](#) section of this Handbook for more information on these programs.

ADSMs are required to be enrolled in TRICARE Prime; however, TRICARE Prime enrollment is not the criteria for treating an ADSM. ADSMs get care at MTFs.

If civilian network care is required, the MTF will provide a referral or request for prior authorization. The Reserve and Service Member Support Office Great Lakes (R&SMSO-GL), (formerly the Military Medical Support Office (MMSO)) will coordinate care in certain circumstances. Once a member's eligibility has been verified (as described previously in this section), care may be delivered and billed for payment.

**Reserve and Service Member Support Office Great Lakes (R&SMSO-GL)**

The R&SMSO-GL is responsible for coordination and management of civilian emergency or referred health care required by active duty Army, Navy, Air Force, Marine Corps, Coast Guard, and certain TRICARE-eligible National Guard and Reserve members. Contact the R&SMSO-GL for more information.

- Reserve and Service Member Support Office Great Lakes
  P.O. Box 886999
  Great Lakes, IL 60088-6999
  888-647-6676
  tricare.mil/tma/mmsos For Priority Mail:

- Reserve and Service Member Support Office
  320 A-B Street
  Great Lakes, IL 60088-6999

ADSM claims must be submitted to PGBA for processing as described in the [Claims Processing and Billing Information](#) section of this Handbook.

**Note:** National Guard and Reserve members seeking medical care for line-of-duty injuries may appear as ineligible in DEERS if they are activated for 30 or fewer days. Refer to [Line-of-Duty Care for National Guard and Reserve Members](#) in the [TRICARE Program Options](#) section of this Handbook for more information.

**Entitlement to Medicare and TRICARE**

TRICARE For Life (TFL) is the Medicare-wrap-around coverage available to all TRICARE beneficiaries, regardless of age and place of residence, provided they have Medicare Part A and Medicare Part B, except as described below. Beneficiaries are eligible for TFL on the date they have both Medicare Part A and Medicare Part B. You can find TFL information at tricare.mil/tfl.

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

- ADFMs remain eligible for TRICARE (i.e., Prime, Standard, or Extra options), while the sponsor is on active duty. However, once the sponsor retires from active duty, the sponsor and his or her family members who are entitled to premium-free Medicare Part A must also have Medicare Part B to keep their TRICARE benefits.
- TRICARE Reserve Select, TRICARE Retired Reserve, CHCBP, and US Family Health Plan beneficiaries are not required to have Medicare Part B to remain covered under these programs.

**Note:** TRICARE advises beneficiaries to sign up for Medicare Part B when first eligible to avoid a break in TRICARE coverage. Beneficiaries who sign up later may have to pay a premium surcharge for as long as they have Part B. The Medicare Part B surcharge is 10 percent for each 12-month period that a beneficiary was eligible to enroll in Part B but did not enroll.
After turning 65, beneficiaries who are not eligible for premium-free Medicare Part A on their own or their current, former, or deceased spouse’s record may remain eligible for TRICARE Prime or TRICARE Standard and TRICARE Extra. They must take the “Notice of Award” and/or “Notice of Disapproved Claim” they receive from the Social Security Administration (SSA) to the nearest ID card-issuing facility to update DEERS and get new ID cards.

Beneficiaries who receive disability benefits from the SSA are entitled to Medicare in the 25th month of receiving disability payments. The Centers for Medicare & Medicaid Services notifies beneficiaries of their Medicare entitlement date. If a beneficiary returns to work and his or her Social Security disability payments are suspended, his or her Medicare entitlement continues for up to eight years and six months. When disability payments are suspended, beneficiaries receive a bill every three months for Medicare Part B premiums, and must continue to pay Medicare Part B premiums to remain eligible for TRICARE coverage.

**Eligibility for TRICARE and Veterans Affairs Benefits**

In some cases, beneficiaries are eligible for benefits under both the TRICARE and VA programs. If a TRICARE beneficiary is also eligible for health care through VA, he or she has the option to use either TRICARE or VA program benefits and health care systems.

Furthermore, TRICARE covers beneficiaries even if they received treatment through VA for the same medical condition in a previous episode of care. However, TRICARE will not duplicate payments made by, or authorized to be made by, VA for treatment of a service-connected disability.

**Note:** Eligibility for health care through VA for a service-connected disability is not considered double coverage.

**Veterans Affairs Benefits as OHI**

If beneficiaries are entitled to Medicare Part A due to age or another reason, they are considered Medicare-eligible, and generally must have Medicare Part B to keep the TRICARE benefit.* TRICARE beneficiaries with Medicare Part A and Part B are covered by TFL, TRICARE’s Medicare-wrap-around coverage. Under TFL, Medicare acts as the primary insurance and TRICARE acts as the secondary payer. VA care is not covered by Medicare, so if a beneficiary seeks care from a VA provider while using the TRICARE benefit, TFL pays first and Medicare pays nothing. In this situation, the beneficiary pays the TRICARE Standard fiscal year (Oct. 1– Sept. 30) deductible, cost-shares, and remaining billed charges. Alternatively, beneficiaries may choose to use the VA benefit when seeing VA providers. To minimize out-of-pocket costs once covered by TFL, beneficiaries should seek care from providers who participate in both TRICARE and Medicare.

**TRICARE Program Options**

TRICARE offers comprehensive medical benefits to all TRICARE beneficiaries, as well as pharmacy and dental benefits. Depending on beneficiary category and location, they may be eligible for different program options. This section provides information on TRICARE program options, including the TRICARE Pharmacy Program and TRICARE Dental Programs.

**TRICARE Prime**

TRICARE Prime is a managed care option (similar to a health maintenance option (HMO)), offered in TRICARE Prime Service Areas (PSAs). PSAs are generally located within 40 miles of a MTF, but may also be located in regions with high numbers of beneficiaries who are not necessarily near MTFs. TRICARE Prime enrollees receive most of their care from an assigned primary care manager (PCM). Wherever possible, a PCM located at an MTF is assigned. At the discretion of the local MTF, a TRICARE network PCM may be assigned or selected if a MTF PCM is not available. The PCM provides and coordinates care, maintains patient medical records, and refers patients to specialists, if necessary. Specialty care referred by the PCM must be approved in advance by UnitedHealthcare.

**Eligibility for TRICARE Prime**

TRICARE Prime is available to ADSMs and their families, retired service members and their dependents, eligible former spouses, and survivors under age 65, as well as certain individuals age 65 or older who are not entitled to premium-free Medicare Part A. National Guard and Reserve members and their families may be eligible for TRICARE Prime in certain circumstances. See the **TRICARE Eligibility** section of this Handbook for instructions on how to verify beneficiary eligibility.

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* Certain beneficiaries may not need Medicare Part B to keep their TRICARE benefit. For more information, visit tricare.mil/tfl.
TRICARE Prime Enrollment Card

Beneficiaries enrolled in TRICARE Prime receive TRICARE Prime 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. An example of the TRICARE Prime enrollment card is shown in Figure 5.1.

TRICARE Prime Enrollment Card

![Enrollment Card](image)

**Figure 5.1**

TRICARE Prime

In addition to their TRICARE Prime enrollment cards, TRICARE Prime beneficiaries must present their uniformed services identification (ID) cards or CACs at the time of service. Although CACs are valid uniformed services ID cards, they do not, on their own, prove TRICARE eligibility. Providers must verify patient eligibility at the time of service by accessing UHCMilitaryWest.com, if registered, or by calling 877-988-9378. Eligibility is also verified as part of the prior authorization process. See the TRICARE Eligibility section of this Handbook for more information about verifying eligibility.

Primary Care Manager

A TRICARE Prime enrollee is assigned or selects a PCM who will provide and coordinate care, maintain patient medical records, and refer the beneficiary to specialists, if necessary. According to TRICARE, a provider who is practicing within the governing state’s rules and regulations may be a PCM when rendering services within a TRICARE PSA. This includes the following PCM types:

- Certified nurse midwives
- Family practitioners
- General practitioners
- Gynecologists
- Internal medicine physicians
- Nurse practitioners
- Obstetricians
- Pediatricians
- Physician assistants

A TRICARE Prime beneficiary relies on his or her PCM for referrals to specialty care providers and services either at MTFs or within the local network. For these services to be covered by TRICARE, the network PCM must submit a referral request to UnitedHealthcare. Once approved, UnitedHealthcare will then issue an authorization for care outside of the MTF.

Reminder: ADSMs always need referrals and prior authorizations for care outside of MTFs.

Providers should submit their requests through the online provider portal. Refer to UHCMilitaryWest.com and the Health Care Management and Administration section of this Handbook for additional information.
There is no requirement for a PCM referral and/or authorization for the following services:

- Those provided by the selected, assigned, or on-call PCM in his or her office
- The first eight visits* for self-referred outpatient mental health care services provided by a network provider in a fiscal year (FY, Oct. 1 – Sept. 30) for medically necessary treatment for covered conditions by network providers who are authorized under TRICARE regulations to see patients independently.
  - There are some provider types who require physician referrals and supervision. Refer to the Behavioral Health Care Services section of this Handbook for additional details. (After the initial eight outpatient mental health care visits, prior authorization and medical necessity reviews are required.)
- Emergency care
- Clinical preventive services from a TRICARE network provider*
- Services received while the beneficiary was using the POS option

See the Important Provider Information section of this Handbook for descriptions of specific PCM roles and responsibilities. TRICARE Prime beneficiaries must receive referrals from their PCMs or UnitedHealthcare for urgent care. If they do not receive referrals, the claims will be paid under the POS option.

UnitedHealthcare will assist with finding specialty care after a referral is requested. TRICARE Prime beneficiaries and retired service members with combat-related disabilities (regardless of program option) may be reimbursed for reasonable travel expenses for medically necessary care if UnitedHealthcare authorizes referrals to specialists located more than 100 miles away from their PCM's office.

For more information on reimbursement of travel expenses for specialty care, refer to the TRICARE Reimbursement Manual, Chapter 1, Section 30 at manuals.tricare.osd.mil.

TRICARE Prime enrollees are required to obtain all care from their PCMs unless referred to another TRICARE-authorized provider. Beneficiaries will be referred to a TRICARE network provider based on availability per the TRICARE access standards. A referral to a non-network TRICARE-authorized provider will only occur if a TRICARE network provider is not available. Refer to the Health Care Management and Administration section of this Handbook for more information about referrals and authorizations.

TRICARE Prime Point-of-Service Option (POS)

A TRICARE Prime beneficiary who uses the POS option may self-refer to any TRICARE-authorized (network or non-network) provider for medical or surgical services. For behavioral health services, the POS option applies when the TRICARE Prime beneficiary receives non-emergency services from a non-network provider. Although a referral is not required when using the POS option, certain prior authorization requirements still apply.

When using the POS option, Prime enrollees pay higher out-of-pocket costs by using a non-network, non-participating provider. The beneficiary is subject to an out of pocket cost of a $300 deductible plus 50 percent of the TRICARE allowable charges. These costs do not accrue toward the beneficiary's catastrophic cap. However, special considerations apply if the beneficiary has OHI. The POS option does not affect the provider's reimbursement, but the beneficiary will pay a larger portion of the TRICARE-allowable charge. To help beneficiaries avoid using the POS option, providers should make sure to note the end date of referrals and to advise beneficiaries when additional referrals are required.

Note: ADSMs may not use the POS option. ADSMs always need referrals and authorizations to receive care outside of MTFs.

Tips to Avoid Unnecessary Point-of-Service Costs

The PCM should provide urgent (non-emergency) care. If the care is being provided because the PCM's office is closed or because the beneficiary is out of area, the beneficiary should call 877-988-9378 as soon as practical to notify UnitedHealthcare that the care has been rendered.

If additional labs, X-rays, and/or minor procedures are required as part of an authorized episode of care, please review the Prior Authorization List at UHCMilitaryWest.com and fax the request, when needed, for the additional services.

Preventive services may also be provided without referrals, except to ADSMs, when performed by network providers. For a listing of preventive benefits, refer to the Medical Coverage section of this Handbook.

* Excludes ADSMs, who always need referrals to receive care outside of MTFs.
TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM)

TPR and TPRADFM provide TRICARE Prime coverage to ADSMs (including activated National Guard and Reserve members) and their families in remote locations through a civilian network of 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 from an MTF designated as adequate to provide primary care may be eligible to enroll in TPR or TPRADFM. To determine if a particular ZIP code falls within a TPR coverage area, use the ZIP code lookup tool at tricare.mil/tprzipcode.

National Guard and Reserve members and their families may be eligible for TPR and TPRADFM in certain circumstances. See the TRICARE Eligibility section of this Handbook for instructions on how to verify patient eligibility.

Accessing Health Care

TPR and TPRADFM beneficiaries select assigned primary care providers to provide primary care services and coordinate specialty care. If there are no network providers in their areas, TPR and TPRADFM beneficiaries may have to choose non-network TRICARE-authorized providers. These beneficiaries may also receive services from military providers if they are willing to travel to MTFs.

ADSMs receive primary care services from their primary care provider without referrals, prior authorizations, or fitness-for-duty reviews. Specialty and inpatient care require referrals and prior authorizations from UnitedHealthcare and the service point of contact (SPOC). ADSMs who do not have PCMs must coordinate requests for specialty care through UnitedHealthcare and the SPOC. The SPOC will determine how to manage referrals if care is related to fitness for duty.

TPRADFM beneficiaries may require referrals for specialty care and/or prior authorizations for certain services. Providers should fax requests for TPR and TPRADFM referral and authorization requests. Refer to the Health Care Management and Administration section of this Handbook or visit UHCMilitaryWest.com > Providers > Referrals and Prior Authorizations for more information.

TPR and TPRADFM Enrollment Cards

Beneficiaries enrolled in TPR and TPRADFM receive TPR 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. Figure 5.2 on the following page shows an example of the TPR enrollment card. Figure 5.3 on the following page shows an example of the TPRADFM enrollment card.

TPR Enrollment Card

![TPR Enrollment Card Figure 5.2](image-url)
In addition to their TPR enrollment cards, beneficiaries must present their uniformed services ID cards or CACs at the time of service. Although CACs are valid uniformed services ID cards, they do not, on their own, prove TRICARE eligibility. Providers must verify patient eligibility at the time of service by accessing UHCMilitaryWest.com, if registered, or by calling 877-988-9378. Eligibility is also verified as part of the prior authorization process. See the TRICARE Eligibility section of this Handbook for more information about verifying eligibility.

TPR and TPRADFM POS Option
The POS option does not apply to TPR ADSMs. If they receive care without referrals or prior authorizations, claims will be forwarded to the Reserve and Service Member Support Office Great Lakes Military Service Point of Contact (SPOC) for payment determination. If the SPOC does not approve the care, the ADSM is responsible for the bill. If the SPOC approves the care, the ADSM does not have copayments, cost-shares, or deductibles. However, TPRADFM beneficiaries are subject to the same POS provisions as TRICARE Prime beneficiaries. They must coordinate care with their primary care providers, or they will be required to pay a deductible and a 50 percent cost-share.

TRICARE Standard and TRICARE Extra
TRICARE Standard is a fee-for-service option that allows beneficiaries to seek care from any TRICARE-authorized non-network provider. TRICARE Extra is a preferred provider option that allows beneficiaries to reduce out-of-pocket costs by visiting TRICARE network providers. TRICARE Standard and TRICARE Extra are available to all TRICARE-eligible beneficiaries except ADSMs. Beneficiaries are responsible for fiscal year (FY, Oct. 1 to Sept. 30) deductibles and cost-shares. Beneficiaries may see any TRICARE-authorized provider they choose, and TRICARE will share the cost of covered services with the beneficiaries after deductibles are met.

For specific cost-shares, visit the TRICARE website at tricare.mil/costs.

TRICARE For Life (TFL)
TFL is TRICARE’s Medicare-wrap-around coverage available worldwide to TRICARE beneficiaries regardless of age, provided they are entitled to premium-free Medicare Part A and also have Medicare Part B. TFL is available to all TRICARE and Medicare dual-eligible* beneficiaries, including retired members of the National Guard and Reserve who receive retired pay, family members, survivors of deceased sponsors, and certain former spouses. Dependent parents and parents-in-law are not eligible for TFL, but may be eligible for space-available care at an MTF. TFL coverage is effective the first day that a TRICARE beneficiary’s Medicare Part A and Part B are effective.

TFL beneficiaries have the freedom to seek care from any Medicare-participating, nonparticipating, or opt-out provider, at MTFs on a space-available basis, or at VA facilities (if eligible). Medicare cannot pay for services received from VA. Therefore, TRICARE is the primary payer for VA claims and beneficiaries will be responsible for the TRICARE annual deductible and cost-shares. Alternatively, beneficiaries may choose to use their VA benefit.

Note: Neither TRICARE nor Medicare will reimburse costs not covered by VA. Providers who opt-out of Medicare are not permitted to bill Medicare however, those providers may bill the beneficiary directly for the services rendered.

Some beneficiaries entitled to premium-free Medicare Part A, including ADSMs, ADFMs, and beneficiaries with TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), and US Family Health Plan (USFHP), may keep their current TRICARE benefits.

* The term “dual-eligible” refers to TRICARE and Medicare dual eligibility and should not be confused with Medicare-Medicaid “dual eligible.”
without Medicare Part B coverage. Medicare allows certain beneficiaries, including ADSMs and ADFMs, to sign up for Medicare Part B during a special enrollment period,* which waives monthly Part B late-enrollment premium surcharges. However, all beneficiaries are strongly encouraged to sign up for Medicare Part B as soon as they become eligible to avoid a break in TRICARE coverage and Medicare monthly late-enrollment premium surcharges.

**Note:** Beneficiaries age 65 and older who are not eligible for premium-free Medicare Part A may remain eligible for TRICARE Prime (if residing in PSAs) or TRICARE Standard and TRICARE Extra. Beneficiaries with only Medicare Part A or only Medicare Part B are not eligible for TFL. Medicare Part B coverage is recommended for TRICARE and Medicare dual-eligible beneficiaries enrolled in the USFHP** TRS, or TRR but it is not required. Refer to “Entitlement to Medicare and TRICARE” in the TRICARE Eligibility section of this Handbook for more information.

**How to Identify TRICARE For Life Beneficiaries**

Each TFL beneficiary must present a valid uniformed services ID card, as well as a Medicare card, prior to receiving services. You should copy both sides of the cards and retain the copies for your files. There is no separate TFL enrollment card. To verify TFL eligibility, contact Wisconsin Physicians Service (WPS/TFL) at 866-773-0404. You may call the SSA at 800-772-1213 to confirm a patient’s Medicare status.

**How TRICARE For Life Works**

The provider first files claims with Medicare. Medicare pays its portion and electronically forwards the claim to WPS/TFL. WPS/TFL sends its payment for TRICARE-covered services directly to the provider. Beneficiaries receive a Medicare Summary Notice from Medicare and a TFL explanation of benefits from WPS/TFL indicating the amounts paid.

• For services covered by both TRICARE and Medicare, Medicare pays first, then TRICARE pays its share of the remaining expenses (unless the beneficiary has OHI).

• For services covered by TRICARE but not by Medicare (such as care received overseas), Medicare pays nothing and TRICARE becomes the primary payer. The beneficiary is responsible for the TRICARE FY annual deductible and cost-shares.

• For services covered by Medicare but not by TRICARE (such as chiropractic care), Medicare is the primary payer and TRICARE pays nothing. The beneficiary is responsible for the Medicare deductible and cost-shares.

• For services not covered by Medicare or TRICARE (e.g., cosmetic surgery), or if Medicare determines the medical services are not medically necessary, the beneficiary is responsible for the entire bill.

**How TRICARE For Life Works with OHI**

TRICARE and Medicare beneficiaries with OHI, such as a Medicare supplement or employer-sponsored health plan, may also use TFL. By law, TRICARE pays claims only after any OHI plans have paid. Typically, after Medicare processes a claim, the claim is forwarded to the beneficiary’s OHI. Once the OHI processes the claim, the beneficiary will need to file a paper claim with TRICARE for any out-of-pocket expenses.

**TRICARE For Life Referrals and Authorizations**

Because Medicare is similar to a preferred provider organization (PPO), and is the primary payer, providers do not need to obtain referrals or prior authorization from UnitedHealthcare. However, dual-eligible beneficiaries may need authorization from UnitedHealthcare if Medicare benefits are exhausted, or for care covered by TRICARE but not Medicare. See the Health Care Management and Administration section of this Handbook for services requiring referrals or authorizations.

If you have questions about TFL, contact WPS/TFL at 866-773-0404 or visit the WPS website at TRICARE4u.com.

See the Claims Processing and Billing Information section of this Handbook for information about filing TFL claims.

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* The special enrollment period does not apply to beneficiaries entitled to Medicare based on end-stage renal disease. These beneficiaries are encouraged to sign up for Medicare Part B when first eligible to avoid the Medicare Part B late-enrollment surcharge.

** USFHP enrollees who develop end-stage renal disease must have Medicare Part B.
TRICARE for the National Guard and Reserve
The seven National Guard and Reserve components include:

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

Line-of-Duty Care for National Guard and Reserve Members
A line-of-duty (LOD), or for Navy and U.S. Coast Guard Reserves, Notice of Eligibility (NOE), condition is determined by the military service and includes any injury, illness, or disease incurred or aggravated while the National Guard and Reserve member is in a duty status, either inactive duty (such as reserve drill) or active duty. This includes the time period when members are traveling directly to or from the place where they perform military duty. National Guard and Reserve members will receive written authorization that specifies the LOD/NOE condition and terms of coverage.

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

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

Services for LOD/NOE conditions are generally delivered at an MTF if there is one nearby that has the capability. The MTF may refer the National Guard or Reserve member to civilian TRICARE providers. If there is no MTF nearby to deliver or coordinate the care, the R&SMSO-GL may coordinate nonemergency care through any TRICARE-authorized civilian provider.

If UnitedHealthcare receives an LOD/NOE claim that was not referred by an MTF or pre-approved by the R&SMSO-GL, UnitedHealthcare will forward the claim to the R&SMSO-GL for approval or denial. The provider should submit medical claims directly to PGBA, UnitedHealthcare’s claims processor, unless otherwise specified on the LOD/NOE written authorization or requested by the National Guard or Reserve member’s Medical Department Representative. Any claims for services submitted for a National Guard or Reserve member with an LOD/NOE condition must be directly related to the condition documented on the LOD/NOE written authorization.

If a claim is denied by the R&SMSO-GL for eligibility reasons, the provider’s office should bill the member. The R&SMSO-GL may approve payment once the appropriate eligibility documentation is submitted. It is the National Guard or Reserve member’s responsibility to ensure that appropriate eligibility documentation is submitted by the unit to the R&SMSO-GL and that all follow-up care is authorized by the R&SMSO-GL SPOC.

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

Family members of these National Guard and Reserve members may also become eligible for TRICARE if the National Guard and 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 use TRICARE Standard and TRICARE Extra. They are also eligible for dental coverage through the TRICARE Dental Program (TDP). Sponsors are required to register their family members in DEERS.
Providers must follow the program rules, benefits, costs, referral and prior authorization requirements, and billing guidelines for the particular program option the family chooses.

**TRICARE Reserve Select (TRS)**

TRS is a premium-based health plan offered by DoD that provides comprehensive health care coverage to qualifying members of the Selected Reserve of the Ready Reserve.

**Verifying TRICARE Reserve Select Coverage**

After purchasing TRS, each member and covered family member receives a TRS enrollment card. 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. You should make a photocopy of the front and back of the card for your files. Providers must verify patient eligibility at the time of service by accessing UHCMilitaryWest.com, if registered, or by calling 877-988-9378. Eligibility is also verified as part of the prior authorization process. See the **TRICARE Eligibility** section of this Handbook for more information about verifying eligibility.

Figure 5.4 shows an example of the TRS enrollment card.

![TRS Enrollment Card](image)

**TRICARE Reserve Select Coverage**

TRS offers comprehensive coverage and patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra. TRS members may access care from any TRICARE-authorized provider, hospital, or pharmacy—network or non-network—without a referral. TRICARE requires prior authorization for certain services. Refer to the UnitedHealthcare Prior Authorization List on UHCMilitaryWest.com > Providers > Referrals and Prior Authorizations for services requiring prior authorization. TRS prior authorization requirements are the same as TRICARE Standard and TRICARE Extra. You may also visit UHCMilitaryWest.com for additional information about submitting referrals and authorizations. See the **Health Care Management and Administration** section of this Handbook for more information.

**Claims and Reimbursement**

See the **Claims Processing and Billing Information** section of this Handbook or visit UHCMilitaryWest.com for details about filing TRS claims.

For more information about the TRS program, visit tricare.mil/trs.

**TRICARE Retired Reserve (TRR)**

TRR is a premium-based health plan offered by the DoD that members of the Retired Reserve under the age of 60 may qualify to purchase.

**Verifying TRICARE Retired Reserve Coverage**

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. You should make a photocopy of the front and back of the card for your files. Providers must verify patient eligibility at the time of service by accessing UHCMilitaryWest.com,
if registered, or by calling 877-988-9378. Eligibility is also verified as part of the prior authorization process. See the TRICARE Eligibility section of this Handbook for more information about verifying eligibility.

Figure 5.5 shows an example of the TRR enrollment card.

**TRR Enrollment Card**

![Sample TRR Enrollment Card](image)

**TRICARE Retired Reserve Coverage**

TRR offers comprehensive coverage and patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra. TRR members may access care from any TRICARE-authorized provider, hospital, or pharmacy—network or non-network—without a referral. TRICARE requires prior authorization for certain services. Refer to the UnitedHealthcare Prior Authorization List on UHCMilitaryWest.com > Providers > Referrals and Prior Authorizations for services requiring prior authorization. TRR prior authorization requirements are the same as TRICARE Standard and TRICARE Extra. You may also visit UHCMilitaryWest.com for additional information about submitting referrals and authorizations. See the Health Care Management and Administration section of this Handbook for more information.

**Claims and Reimbursement**

See the Claims Processing and Billing Information section of this Handbook or visit UHCMilitaryWest.com for details about filing TRR claims.

For more information, visit the TRR website at tricare.mil/trr.

**TRICARE Young Adult (TYA)**

The TYA program is a premium-based health care 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 service sponsor and where they live. TYA includes medical and pharmacy benefits, but excludes dental coverage.

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

- A dependent of an eligible uniformed service sponsor*
- Unmarried
- At least age 21 (or age 23 if enrolled in a full-time course of study at an approved institution of higher learning and if the sponsor provides over 50 percent of the financial support), but have not yet reached age 26. TYA eligibility terminates on the dependent’s 26th birthday.
- Not eligible to enroll in an employer-sponsored health plan as defined in TYA regulations
- Not otherwise eligible for TRICARE program coverage

For more information on TYA, visit tricare.mil/tya.

**TYA Enrollment Card**

Beneficiaries enrolled in TYA receive TYA 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. Figure 5.6 shows an example of the TYA enrollment card.

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* If the beneficiary is an adult child of a non-activated member of the Selected Reserve of the Ready Reserve or of the Retired Reserve, their sponsor must be enrolled in TRICARE Reserve Select or TRICARE Retired Reserve to be eligible to purchase TYA coverage.
In addition to their TYA enrollment cards, beneficiaries must present their uniformed services ID cards at the time of service. Although CACs are valid uniformed services ID cards, they do not, on their own, prove TRICARE eligibility. Providers must verify patient eligibility at the time of service on UHCMilitaryWest.com, if registered, or by calling 877-988-9378. Eligibility is also verified as part of the prior authorization process. See the TRICARE Eligibility section of this Handbook for more information about verifying eligibility.

**TRICARE Pharmacy Program**

TRICARE provides a world-class pharmacy benefit. TRICARE beneficiaries—including Medicare-eligible beneficiaries—are eligible for the TRICARE Pharmacy Program.

The TRICARE Pharmacy Program is managed by Express Scripts, Inc.

**Note:** Medicare-eligible beneficiaries who turned 65 after April 1, 2001, must enroll in Medicare Part B and confirm their DEERS profile is updated to use the TRICARE pharmacy benefit.

Eligible beneficiaries may use any of these options to have a written prescription filled:

- **MTF pharmacies:** Using an MTF pharmacy is the least expensive option, but formularies may vary by MTF pharmacy location. Contact the local MTF pharmacy to check availability before prescribing a medication.

- **TRICARE Pharmacy Home Delivery:** TRICARE Pharmacy Home Delivery (formerly TRICARE Mail Order Pharmacy) is the preferred method when not using an MTF pharmacy.

- **TRICARE retail network pharmacies:** Beneficiaries may access a network of approximately 60,000 retail pharmacies in the United States and certain U.S. territories* (Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

- **Non-network retail pharmacies:** Filling prescriptions at a non-network retail pharmacy is the most expensive option and is not recommended to beneficiaries.

To have a prescription filled, beneficiaries will need a prescription and a valid uniformed services ID card. All prescriptions filled through TRICARE Pharmacy Home Delivery must have the prescriber's handwritten signature.

**Note:** USFHP participants may only use the pharmacy benefits provided under that program.

For more information on the TRICARE Pharmacy Program, visit tricare.mil/pharmacy or express-scripts.com/TRICARE or call Express Scripts, Inc. (Express Scripts) at 877-363-1303.

**Member Choice Center**

TRICARE established the Member Choice Center (MCC) to help TRICARE beneficiaries transfer their retail pharmacy prescriptions to home delivery. Beneficiaries may call the MCC at 877-363-1433 or access information online by visiting tricare.mil/pharmacy or express-scripts.com/TRICARE.

When TRICARE beneficiaries contact the MCC, an Express Scripts patient-care advocate will verify their information and walk them through the conversion process. To help facilitate the process, the patient-care advocate may contact you to have your patient’s prescriptions transferred to TRICARE Pharmacy Home Delivery.

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* Currently, there are no TRICARE retail network pharmacies in American Samoa.
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 assessment that indicates the brand-name drug is medically necessary and after Express Scripts grants approval. If your patient requires a brand-name medication that has a generic equivalent, you must obtain prior authorization. Otherwise, the patient may be responsible for the entire cost of the medication.

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

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

Visit tricare.mil/pharmacyformulary for a general list of TRICARE-covered prescription drugs that require prior authorization and to access prior authorization and medical necessity criteria forms for retail network and home delivery prescriptions. MTF pharmacies may follow different procedures. The top of each form contains information on where to send the completed form. For assistance, call Express Scripts at 877-363-1303.

Uniform Formulary Drugs and Non-Formulary Drugs
DoD has established a uniform formulary, which is a list of covered generic and brand-name drugs. The formulary also contains a third tier of medications that are designated as “non-formulary.” The DoD P&T Committee may recommend to the director of the DHA that certain drugs be placed in the third, “non-formulary” tier. These medications include any drug in a therapeutic class determined to be not as relatively clinically effective or as cost-effective as other drugs in the same class.

For a higher copayment, third-tier drugs are available through TRICARE Pharmacy Home Delivery or retail network pharmacies. A beneficiary may be able to fill a non-formulary prescription at formulary costs if the provider can establish medical necessity by completing and submitting the appropriate TRICARE Pharmacy Program medical necessity form to Express Scripts for the non-formulary medication. Visit tricare.mil > See What’s Covered > Pharmacy > Prescription Drugs > Non-Formulary Drugs to download the form.

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

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

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

Call Express Scripts at 877-363-1303 or visit pec.ha.osd.mil/forms_criteria.php for forms and medical-necessity criteria. To learn more about medications and common drug interactions, check for generic equivalents, or determine if a drug is classified as a non-formulary medication, visit the online TRICARE Formulary Search Tool at pec.ha.osd.mil > Formulary Search Tool.

Step Therapy
Step therapy involves prescribing a safe, clinically effective, and cost-effective medication as the first step in treating a medical condition. The preferred medication is often a generic medication that offers the best overall value in terms of safety, effectiveness, and cost. Non-preferred drugs are only prescribed if the preferred medication is ineffective or poorly tolerated.
Drugs subject to step therapy will only be approved for first-time users after they have tried one of the preferred agents on the DoD Uniform Formulary (e.g., a patient must try omeprazole or Nexium® prior to using any other proton pump inhibitor).

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

For a complete list of medications subject to step therapy, see “Medications Identified by the DoD P&T Committee” at tricare.mil/pharmacy > Prescription Drugs > Step Therapy.

**Medicare-Eligible Beneficiaries**
Medicare-eligible beneficiaries are able to use the TRICARE Pharmacy Program if they are eligible for Medicare Part A and enrolled in Medicare Part B. If they do not have Medicare Part B, they may only access pharmacy benefits at MTFs.* 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.

You may direct eligible beneficiaries who inquire about Medicare Part D coverage to visit tricare.mil/medicarepartd. However, for the most up-to-date information on the Medicare Part D prescription drug benefit, beneficiaries should call Medicare at 800-MEDICARE/800-633-4227 or visit the Medicare website at medicare.gov.

**Pharmacy Data Transaction Service (PDTS)**
The PDTS is a centralized data repository that records information about DoD beneficiaries’ prescriptions. PDTS allows providers to access complete patient medication histories, helping to increase patient safety by reducing the likelihood of adverse drug interactions, therapeutic overlaps, and duplicate treatments. PDTS conducts an online prospective drug-utilization review (i.e. a clinical screening) in real time against a beneficiary’s complete medication history for each new or refilled prescription before it is dispensed to the patient. Regardless of where a beneficiary fills a prescription, prescription information is stored in a robust central data repository and is available to authorized PDTS providers, including TRICARE Pharmacy Home Delivery, MTF pharmacies, MTF providers, and TRICARE retail network pharmacies.

**Specialty Medication Care Management**
Specialty medications are usually high-cost, self-administered, injectable, oral, or infused drugs that treat serious chronic conditions (e.g., multiple sclerosis, rheumatoid arthritis, hepatitis C). These drugs typically require special storage and handling and are not readily available at local pharmacies. Specialty medications may also have side effects that require pharmacist and/or nurse monitoring. The Specialty Medication Care Management program is structured to improve the beneficiary’s health through continuous health evaluation, ongoing monitoring, assessment of educational needs, and management of medication use. This program provides:

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

These services are provided to beneficiaries at no additional cost when they receive their medications through TRICARE Pharmacy Home Delivery, and participation is voluntary. If you or your patient orders a specialty medication from TRICARE Pharmacy Home Delivery, Express Scripts sends the patient additional information about the Specialty Medication Care Management program and how to get started.

Beneficiaries enrolled in the Specialty Medication Care Management program have access to pharmacists 24 hours a day, seven days a week. The specialty clinical team reaches out to the beneficiaries’ physicians, as needed, to address beneficiary issues, such as side effects or disease exacerbations. If any of your patients currently fill specialty medication prescriptions at retail pharmacies, the specialty clinical team will provide brochures detailing the program as well as prepopulated enrollment forms.

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

* Exceptions exist for certain beneficiaries, including ADSMs and ADFMs. Please see TRICARE For Life earlier in this section for more information.
Note: Some specialty medications may not be available through TRICARE Pharmacy Home Delivery because the manufacturer limits the drug’s distribution to specific pharmacies. If you submit a prescription for a limited-distribution medication, TRICARE Pharmacy Home Delivery either forwards the prescription to a pharmacy of the patient’s choice that can fill it or provides the patient with instructions about where to send the prescription. To determine if a specialty medication is available through TRICARE Pharmacy Home Delivery, visit pec.ha.osd.mil > Formulary Search Tool.

TRICARE Dental Options
The TRICARE medical benefit covers adjunctive dental care (e.g., dental care that is medically necessary to treat a covered medical condition). Additionally, several non-adjunctive dental care options are available to eligible beneficiaries. ADSMs receive dental care at military dental treatment facilities (DTFs) or from civilian providers through the TRICARE Active Duty Dental Program (ADDP), if necessary. For all other beneficiaries, TRICARE offers two premium-based dental programs—the TRICARE Dental Program (TDP) or the TRICARE Retiree Dental Program (TRDP). Each program is administered by a separate dental contractor and has its own monthly premiums and cost-shares.

Note: TRICARE may cover some medically necessary services in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental, or physical disabilities and children age 5 and younger. See the Medical Coverage section of this Handbook for more details.

TRICARE Active Duty Dental Program (ADDP)
The ADDP is administered by United Concordia Companies, Inc. (United Concordia), and provides civilian dental care to ADSMs who are referred for care by a military DTF or who serve duty and reside greater than 50 miles from a DTF. Visit addp-ucci.com or tricare.mil/dental for more information.

TRICARE Dental Program (TDP)
The TDP is a voluntary dental insurance program available to eligible ADFMs and National Guard and Reserve and Individual Ready Reserve members and their eligible family members. ADSMs (and National Guard and Reserve members called to active duty for a period of more than 30 consecutive days or eligible for the pre-activation benefit up to 180 days prior to their report date) are not eligible for the TDP. They receive dental care at military DTFs or through the ADDP.

Visit tricare.mil/dental for more information.

TRICARE Retiree Dental Program (TRDP)
The TRDP is a voluntary dental insurance program administered by Delta Dental® of California (Delta Dental). The TRDP offers comprehensive, cost-effective dental coverage for uniformed services retirees and their eligible family members, retired National Guard and Reserve members (including those who are entitled to retired pay but will not begin receiving it until age 60) and their eligible family members, certain surviving family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors.

For more information, visit the TRDP website at trdp.org, or call Delta Dental at 888-838-8737.

Cancer Clinical Trials
The DoD Cancer Prevention and Treatment Clinical Trials Demonstration was conducted from 1996 through March 2008 to improve access to promising new cancer therapies, assist in meeting the clinical trial goals of the National Cancer Institute (NCI), and assist in the formulation of conclusions regarding the safety and efficacy of emerging therapies in the prevention and treatment of cancer. Effective April 1, 2008, participation in cancer clinical trials was adopted as a permanent TRICARE benefit.

Note: TRICARE beneficiaries who began participation in the demonstration prior to its termination will continue to receive services as a demonstration participant until the beneficiary is discharged from the clinical trial.

There are three categories of NCI clinical trials:

- Phase I trials: TRICARE beneficiaries may be eligible to participate in Phase I trials if they meet certain requirements. Phase I trials are primarily concerned with assessing a drug’s safety and tolerability.
- Phase II trials: TRICARE beneficiaries may participate in Phase II trials, which study the safety and effectiveness of an agent or intervention on a particular type of cancer and evaluate how it affects the human body.
• Phase III trials: TRICARE beneficiaries may also participate in Phase III trials, which compare promising new treatments against the standard approaches. These studies also focus on particular types of cancers.

Cost of Participation
TRICARE will cost-share all medical care and testing required to determine eligibility for an NCI-sponsored trial. All medical care required as a result of participation in a trial will be processed under normal reimbursement rules (subject to the TRICARE maximum-allowable charge), provided each of the following conditions is met:

• The provider seeking treatment for a TRICARE-eligible beneficiary in an NCI-approved protocol has obtained prior authorization for the proposed treatment before initial evaluation
• The treatments are NCI-sponsored Phase I, II, or III protocols
• The patient continues to meet entry criteria for the protocol
• The institutional and individual providers are TRICARE-authorized providers

How to Participate
Prior authorization is required to participate in an NCI clinical trial. Providers may use the Cancer Clinical Trial (CCT) Patient Authorization form to refer a TRICARE beneficiary into an NCI clinical trial. To download the form, visit UHCMilitaryWest.com > Providers > Find A Form > Clinical Programs.

Before beginning the evaluation or any treatment under the clinical trial, contact a UnitedHealthcare Cancer Clinical Trials Coordinator at 888-899-4933 from eight a.m.–5 p.m. MT, Monday through Friday.

Note: A beneficiary participating in an NCI clinical trial may still require a referral or authorization for non-NCI clinical trial services. Refer to the Health Care Management and Administration section of this Handbook for additional information.

The NCI website at cancer.gov lists some of the Phase I, Phase II, and Phase III NCI-sponsored clinical trials, but not all of them. To determine if there are clinical trials available, contact a Clinical Trials Coordinator at 888-899-4933.

TRICARE Extended Care Health Option (ECHO)
ECHO provides services to ADFMs who qualify based on specific mental or physical disabilities and offers beneficiaries an integrated set of services and supplies beyond those offered by the basic TRICARE health benefit programs (e.g., TRICARE Prime, TPRADFM, TRICARE Standard and TRICARE Extra).

Each beneficiary obtaining ECHO and associated program benefits is assigned to a case manager or a service coordinator who will assist in coordinating care with the PCM.

Potential ECHO beneficiaries must be ADFMs, have qualifying conditions, and be registered in the Exceptional Family Member Program (EFMP). Other circumstances exist that make enrollment in the EFMP unnecessary or inappropriate, such as when an individual resides with the custodial parent who is not the active duty sponsor. Each service branch has its own EFMP and enrollment process. To learn more, contact the service branch’s EFMP representative or visit tricare.mil. A record of ECHO registration is stored with a beneficiary’s DEERS information.

Conditions qualifying an ADFM for ECHO coverage include, but are not limited to:

• Moderate or severe mental retardation
• A serious physical disability
• An extraordinary physical or psychological condition of such complexity that the beneficiary is homebound
• A diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler (under age 3) that is expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability
• Multiple disabilities, which may qualify if there are two or more disabilities affecting separate body systems

TRICARE providers, especially PCMs, are responsible for managing care for TRICARE beneficiaries. Any TRICARE provider (PCM or specialist) may inform the patient’s sponsor about the ECHO benefit. Beneficiaries should be referred to UnitedHealthcare for assistance with eligibility determination and ECHO registration. This can help the beneficiary and care provider gain a better understanding of the benefit and will help make sure you have taken the necessary steps for efficient claims processing.
Active duty sponsors with family members seeking ECHO registration must enroll in their service’s EFMP as required by their service branch. Retroactive registration into the ECHO program is not allowed.

**ECHO Provider Responsibilities**

ECHO providers have certain responsibilities:

- Prior authorization must be obtained from UnitedHealthcare for all care provided under the ECHO program or providers run the risk of having ECHO claims denied.
- Providers may be requested to provide medical records or assist beneficiaries with completing EFMP documents.
- Network and participating providers must submit ECHO claims to PGBA.

For the Comprehensive Autism Care Demonstration, a provider rendering applied behavior analysis reinforcement (ABA Reinforcement) must be supervised by TRICARE-certified provider that meets one of the following criteria:

- Has a current Behavior Analyst state license to provide ABA services, or
- Is certified by the Behavior Analyst Certification Board™ as either a Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA).

For more information, see “TRICARE Comprehensive Autism Care Demonstration (ACD)” later in this section.

**ECHO Benefits**

ECHO provides coverage for the following products and services:

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

TRICARE may pay for “hands-on” one-on-one behavioral interventions provided by TRICARE-authorized providers. However, TRICARE does not authorize payment for any services provided by family members, trainers, or other individuals who are not TRICARE-certified.
**ECHO Home Health Care Benefit (EHHC)**

The EHHC benefit covers expanded respite care and in-home medically necessary skilled services through TRICARE EHHC.

- EHHC respite care: up to eight hours per day, five days per week to provide relief for the primary caregivers*
- EHHC skilled nursing to assist eligible beneficiaries in remaining in their home residence in lieu of an institution
- EHHC provides homebound beneficiaries requiring skilled, extended in-home health care services that are:
  - Not limited to part-time or intermittent
  - Capped by cost, not by hours (using the skilled nursing facility reimbursement rate)

For more information regarding the EHHC, refer to the TRICARE Policy Manual, Chapter 9, Section 15.1 at manuals.tricare.osd.mil.

**ECHO Costs**

All ECHO services (including EHHC) accrue to the government’s maximum FY cost-share of $36,000. Maximum cost-share limits under ECHO are per family, regardless of the number of dependents with the same sponsor receiving ECHO benefits in that period.

Costs for EHHC services do not accrue to the government’s maximum FY cost-share.

Cost-shares under ECHO are in addition to those incurred for services provided under the basic TRICARE benefit (e.g., TRICARE Prime, TPRADFM, TRICARE Standard and TRICARE Extra).

**Note:** ECHO cost-shares do not accrue toward the catastrophic cap.

**Prior Authorizations**

Providers must request prior authorization for all ECHO services.

**Claims**

See the Claims Processing and Billing Information section of this Handbook for details on filing ECHO claims.

**For More Information**

For more information regarding ECHO, refer to the TRICARE Policy Manual, Chapter 9 at manuals.tricare.osd.mil. Refer to the following resources for additional information and assistance:

- ECHO Information and Referral Line: 855-874-6800
- ECHO Nurses: Call the UnitedHealthcare Case Management Center at 866-480-0070 and enter the extension for the beneficiary’s ECHO nurse. **Note:** ECHO beneficiaries should call the ECHO Information and Referral line 855-874-6800 if they have lost or forgotten contact information for their ECHO nurse.
- ECHO fax number: 877-890-8156
- UHCMilitaryWest.com > Beneficiary > Case Management Program > Extended Care Health Option
- ECHO website: tricare.mil/echo
- EFMP information: militaryonesource.mil/efmp

**TRICARE Comprehensive Autism Care Demonstration (CACD) Program**

The Comprehensive Autism Care Demonstration ("Autism Care Demonstration") combines all TRICARE-covered Applied Behavior Analysis (ABA) services under one demonstration and provides TRICARE reimbursement for ABA and related services to TRICARE eligible beneficiaries diagnosed with Autism Spectrum Disorder (ASD). TRICARE covers ABA for all TRICARE eligible beneficiaries who are diagnosed with an Autism Spectrum Disorder. All ABA services require prior authorization.

**Autism Program Key Terms**

- ADOS-2 -Autism Diagnostic Observation Schedule, Second Edition
- Applied Behavior Analysis (ABA)

* ECHO respite care benefits can only be used in a month when another ECHO benefit is being received. Both respite benefits (ECHO respite and EHHC respite) cannot be used in the same calendar month. The respite benefits cannot be used for siblings, employment, deployment, or pursuing education, respite benefits are not accumulative (i.e., unused hours cannot be carried over into the next month).
• BCBA-D: Board Certified Behavior Analyst-Doctoral level
• BCBA: Board Certified Behavior Analyst-Masters level
• BCaBA: Board Certified Assistant Behavior Analyst-Bachelor level
• BT: Behavior Technician
• EIA: Educational Interventions for Autism
• Vineland II -Vineland Adaptive Behavior Scales, Second Edition
• ABLLS-R: Assessment of Basic Language and Learning Skills – Revised
• ASD: Autism Spectrum Disorder
• VB-MAPP: Verbal Behavioral Milestone Assessment Placement Program
• ACSP: Autism Corporate Service Provider

The active duty family member (ADFM) must be enrolled in ECHO in order to receive ABA services under CACD. The CACD services do not apply to the $36,000 ECHO cap and are considered ECHO-eligible services to access respite care under ECHO. The ECHO cost share satisfies the CACD cost share requirement.

**ABA Therapy — Sole Delivery Model**
Covered ABA delivered by BCBAs, BCBA-Ds under the Sole Delivery Model includes:

• Functional Behavioral Assessment and Analysis/Initial Behavioral Plan
• Direct ABA services to the beneficiary
• Updated ABA Treatment Plan
• ABA intervention training to family member/caregivers
• Adaptive Behavioral Treatment Modification Additionally, for the Sole Delivery Model:
  • ABA Therapy is only provided by BCBA/BCBA-D
  • This service requires prior approval based on an Outpatient Treatment Request with a plan that is consistent with the assessment and diagnosis

**ABA Tiered Delivery Model**
Covered ABA may be delivered by Board Certified Assistant Behavior Analysts, and Behavior Technicians (BTs) under the supervision of Board Certified Behavior Analysts (BCBAs/BCBA-Ds) thus creating a tiered treatment delivery model.

The Tiered Delivery Model includes:

• Functional Behavioral Assessment and Analysis/Initial Behavioral Plan developed by BCBAs/BCBA-Ds or delegated BCaBA directly reviewed and approved by the BCBAs/BCBA-Ds
• ABA Treatment Plan protocol interventions to the beneficiary by the BCBAs/BCBA-Ds, BCaBAs or BTs
• Updated ABA Treatment Plan delivered by BCBAs/BCBA-Ds or delegated BCaBA directly reviewed and approved by the BCBAs/BCBA-Ds
• ABA intervention training to family member/caregivers delivered by BCBAs/BCBA-Ds or delegated BCaBA directly reviewed and approved by the BCBAs/BCBA-Ds
• Adaptive Behavioral Treatment Modification developed by BCBAs/BCBA-Ds or delegated BCaBA directly reviewed and approved by the BCBAs/BCBA-Ds

**Note:** This service requires prior approval based on an Outpatient Treatment Request with a treatment plan that is supported by the assessments.
ABA Treatment Plan Protocol Interventions under the Autism Care Demonstration

The demonstration covers ABA Treatment Plan Protocol Interventions that:

- Implement basic principles of Applied Behavior Analysis and target behaviors associated with the core deficits of ASD.
- Focus on changing the child’s behavior by observing and measuring the behavior in real-life environments.
- Gather behavioral data to track progress in reaching behavioral objectives identified in the Treatment Plan and periodically modifies the plan to adapt to the child’s response to the intervention.
- Incorporate parent training so family members/caregivers can teach and support skills during typical family activities.

Authorized supervisors will be required to direct and oversee the BCaBAs and Behavior Technicians who provide the “hands-on” one-to-one intervention services and verify that the BCaBA and BT are trained and able to perform the services required to treat the beneficiary with autism. Authorized supervisors under the CACD are BCBAs and BCBA-Ds. Under the direct supervision and accountability of the primary BCBA and BCBA-D, BCaBAs may render delegated supervision of the BT interventions. All ABA services require prior authorization.

Prior Authorizations and Referrals for Autism Services

ACD Services require prior authorization and providers must include supporting clinical documentation.

When using the fax process for autism services, please submit clinical information and the TRICARE Service Request/Notification Form. You can find the TRICARE Service Request/Notification Form on:

UHCMilitaryWest.com > Provider > Find a Form > Medical-Surgical Referrals and Authorizations > Autism Care Demo Form.

The standard response time for autism authorizations is routinely five business days, and one business day for medically necessary urgent requests. You may fax routine or urgent authorizations to 877-890-8156.

For more details please reference the Health Care Management and Administration section.

For questions regarding authorizations or treatment plans, providers may call the Autism Clinical team at 855-874-6800.

Autism BCBA, BCBA-D, BCaBA, and Behavior Technician Demographic Changes

Demographic changes related to staffing and office locations must be submitted to UnitedHealthcare by notifying us by email at tricare_autism@optum.com. We will send you the paperwork to complete to update our systems.

For BCaBA/Behavior Technician updates/additions, be advised that groups must complete the attestation process prior to servicing TRICARE beneficiaries. Please email us at tricare_autism@optum.com and allow at least two weeks for completion. We will send you the electronic attestation forms to begin the certification process.

For Autism claim submission on a Form 1500:

Demographic and provider identifier information is auto-populated if you submit your claims through Express Claims on myTRICARE.com. If you submit claims through a clearinghouse, make sure to follow the following demographic and provider identifier guidelines:

- For Block 12: the patient or the parent has to provide their signature, unless the provider has this signature on file.
- Each service date must be listed separately on a service line.
- Valid service codes should be included for each line, with number of units.
- A service line should list the individual rendering the service. This applies to every service line.
- If a supervisor and BCaBA/Behavior Technician are seeing a beneficiary on the same date, include the start and stop times for both the supervisor and the BCaBA/Behavior Technician on the claim, respectively. Note: The claims process will be denied without the session dates and times. Only the supervisor services will be paid if billed during the same hour as a BCaBA/Behavior Technician service.
• If multiple BCaBAs or Behavior Technicians are seeing a patient on the same date, include the start and stop times for each BCaBA or Behavior Technician respectively. **Note:** The claims process will be denied without the session times and only one BCaBA or Behavior Technician will be applied if billing for multiple ABA services during the same hour.

• For BCaBA/Behavior Technicians, 0364T/0365T (30 minute increments) are the appropriate codes for ABA Treatment Plan Interventions.

• For 0364T/0365T, when the BCaBA/Behavior Technician is a rendering provider, claims must include the UnitedHealthcare system-generated carrier number or SSN for the Behavior Technician. For 0364T/0365T, when the BCaBA is a rendering provider, claims must include the NPI number in the rendering field (Block 24J).

• A group can bill more than one BCaBA/Behavior Technician on a claim, if submitted through an EDI, but each date and service line should list the individual rendering the service. This applies to every service line.

• Providers should use the group Tax ID in Block 25 and the group NPI in Block 33A.

• For Block 31 – the provider or an office representative must sign on behalf of the office.

**Valid Codes**
The following codes are typical codes used for ABA, ECHO, EHHC, and Warrior Support Authorizations. These are typical codes and are not all inclusive.

**Note:** Autism codes are subject to change and any updates or revisions will be communicated if needed.

**ABA, ECHO, EHHC, Warrior Support Codes**

<table>
<thead>
<tr>
<th>Comprehensive Autism Care Demonstration</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Single unit of service) Behavior identification assessment, by the physician or other qualified health care professionals, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with primary guardian(s)/caregiver(s),and preparation of report. May only be reported once within a defined time period, which for this demonstration is once every six months for the initial ABA assessment and ABA TP and the semi-annual ABA reassessment, progress measurement report and TP update. (BCBA or BCBA-D)</td>
<td></td>
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</tr>
<tr>
<td>(Initial 30 minutes, per rendering provider, per day) Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time. Initial 30 minutes of ABA TP protocol interventions provided during one-on-one with the beneficiary. (BCBA/BCBA-D, BCaBA or Behavior Technician)</td>
<td></td>
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</tr>
<tr>
<td>(Each additional 30 minutes per rendering provider, per day) Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time. CPT4 0364T and 0365T are timed codes based on units of service in 30 minute increments. CPT4 0364T and 0365T are reimbursed at the same rate per unit of service regardless of who delivers this service (Behavior Technician, BCaBA or BCBA, BCBA-D, or other TRICARE authorized provider practicing within the scope of their state licensure or state certification).</td>
<td></td>
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</tr>
<tr>
<td>(Initial 30 minutes, per rendering provider, per day) Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient. Behavior Technicians must be supervised through direct observation for thirty minutes for every 10 hours of one-on-one ABA per week (5 percent) in accordance with the BACB Guidelines. CPT4 0360T for the first 30 minutes. (BCBA or BCBA-D)</td>
<td></td>
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</tr>
<tr>
<td>(Each additional 30 minutes, per rendering provider, per day) Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional minutes of technician time, face-to-face with the patient. Behavior Technicians must be supervised through direct observation for 30 minutes for every 10 hours of one-on-one ABA per week (5 percent) in accordance with the BACB Guidelines. Each additional 30 minute increment of supervised field work of Behavior Technicians. BCBAs, BCBA-Ds, and other TRICARE authorized providers are the only providers that shall bill and receive reimbursement for supervised field work. (BCBA or BCBA-D)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Initial 30 minutes, per rendering provider, per day) Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time. Used by BCBA, BCBA-D, or other TRICARE authorized providers for direct one-on-one time with one beneficiary to demonstrate a new or modified protocol to a Behavior Technician and or TRICARE eligible parents/caregivers. CPT5 0368T and 0369T are timed 30 minute increment codes. (BCBA or BCBA-D)</td>
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</table>
### Comprehensive Autism Care Demonstration

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0369T</td>
<td>(Each additional 30 minutes, per rendering provider, per day) Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time. Used by BCBA, BCBA-D, or other TRICARE authorized providers for direct one-on-one time with one beneficiary to demonstrate a new or modified protocol to a Behavior Technician and/or TRICARE eligible parents/caregivers. CPT5 0368T and 0369T are timed 30 minute increment codes. Adaptive Behavior Treatment by Protocol Modification, are codes used by BCBA, BCBA-D, or other TRICARE authorized providers for direct one-on-one time with one beneficiary to demonstrate a new or modified protocol to a Behavior Technician and/or TRICARE eligible parents/caregivers. CPT5 0368T and 0369T are timed 30 minute increment codes. (BCBA or BCBA-D)</td>
</tr>
<tr>
<td>0370T</td>
<td>(Single unit of service) Family adaptive behavior treatment guidance; administered by physician or other qualified health care professional (without the patient present). Used by the BCBA, BCBA-D or other TRICARE authorized providers for teaching the TRICARE eligible parents/caregivers to utilize the ABA TP protocols to reduce maladaptive behaviors without the beneficiary present during a one-on-one encounter. (BCBA or BCBA-D)</td>
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### ECHO Home Health Care (EHHC) CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>S9122</td>
<td>Home health aide in the home, per hour</td>
</tr>
<tr>
<td>S9123</td>
<td>Nursing care in the home RN, per hour</td>
</tr>
<tr>
<td>S9124</td>
<td>Nursing care in the home LPN, per hour</td>
</tr>
<tr>
<td>99347</td>
<td>Home visit for the evaluation and management of an established patient, which requires at least two or three key components: A problem focused interval history, a problem focused examination, straightforward medical decision making.</td>
</tr>
<tr>
<td>99348</td>
<td>Home visit for the evaluation and management of an established patient, which requires at least two or three key components: An expanded problem focused interval history, an expanded problem focused examination, medical decision making of low complexity.</td>
</tr>
<tr>
<td>99349</td>
<td>Home visit for the evaluation and management of an established patient, which requires at least two or three key components: A detailed interval history, a detailed examination, medical decision making of moderate complexity.</td>
</tr>
<tr>
<td>99350</td>
<td>Home visit for the evaluation and management of an established patient, which requires at least two or three key components: A comprehensive interval history, a comprehensive examination, medical decision making of moderate to high complexity.</td>
</tr>
<tr>
<td>99600</td>
<td>Unlisted home visit service or procedure (ICMP-PEC)</td>
</tr>
</tbody>
</table>

### Hippotherapy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9240</td>
<td>Equestrian/hippotherapy, per session</td>
</tr>
</tbody>
</table>

### Warrior Support Services Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9122</td>
<td>Home health aide in home, per hour</td>
</tr>
<tr>
<td>S9123</td>
<td>Nursing care in the home RN, per hour</td>
</tr>
<tr>
<td>S9124</td>
<td>Nursing care in the home LPN per hour</td>
</tr>
</tbody>
</table>

### Supplemental Health Care Program (SHCP)

TRICARE is derived from the Civilian Health and Medical Program of the Uniformed Services, which technically does not cover ADSMs (or National Guard and Reserve members on active duty). However, similar to TRICARE, the SHCP provides coverage for ADSMs (except those enrolled in TPR) and non-active duty individuals under treatment for LOD/NOE conditions. The SHCP also covers health care services ordered by an MTF provider for a non-ADSM MTF patient for whom the MTF provider maintains responsibility. Although the SHCP is funded by the DoD, it is separate from TRICARE and follows different rules. Only the following individuals are eligible for the SHCP:

- ADSMs assigned to MTFs
- ADSMs on travel status (e.g., leave, temporary assignment to duty, or permanent change of station)
- Navy or Marine Corps service members enrolled to deployable units and referred by the unit PCM or other provider who is not an MTF PCM
- National Guard and Reserve members on active duty
- National Guard members (LOD care only, unless beneficiary is on active federal service)
- National Oceanic and Atmospheric Administration personnel, U.S. Public Health Service personnel, cadets or midshipmen, and eligible foreign military personnel
• Non-active duty beneficiaries when they are inpatients in an MTF and are referred to a civilian facility for a test or procedure unavailable in the MTF, provided the MTF maintains continuity of care over the inpatient and the beneficiary is not discharged from the MTF prior to receiving services

• Comprehensive Clinical Evaluation Program participants

• Beneficiaries on the Temporary Disability Retirement List are eligible to obtain required periodic physical examinations

• Medically retired former members of the armed services enrolled in the Federal Recovery Coordination Program

Note: SHCP beneficiaries are not responsible for cost-shares, copayments, or deductibles.

Civilian Care
When SHCP individuals need services that are not available at the MTF, the MTF physician issues a referral to a civilian provider. Care referred or authorized by the MTF and/or the R&SMSO-GL will be covered under the SHCP.

Referrals and Authorizations
The MTF (if one is available) or the R&SMSO-GL will initiate referrals for ADSMs and other designated patients to civilian specialists and sub-specialists for services that are beyond the scope of primary care. If it is determined that services are unavailable at the MTF, a Referral For Civilian Medical Care (DD Form 2161) (this form may vary by MTF site) will be completed and sent to UnitedHealthcare prior to sending the patient for specialty care. UnitedHealthcare and the MTF, as appropriate, will agree on a civilian provider to administer the care and will notify the patient. For non-MTF referred care, the SPOC will determine if the ADSM will receive care from an MTF or civilian provider.

Civilian providers should accept the electronic signature on forms (form number may vary) as valid ordering-physician signatures. There are numerous security mechanisms to ensure HIPAA compliance and that the electronic signature is made by the ordering DoD provider.

Electronic signatures can only be made by physicians and physician extenders with prescriptive and referral authority.

Provider Responsibilities Under the SHCP Program
Network providers are required to adhere to all contract requirements when treating SHCP individuals, including office and appointment access standards. Refer to the Important Provider Information section of this Handbook for more information about provider responsibilities.

UnitedHealthcare requires that all civilian providers who see referred SHCP individuals provide the referring MTF physician with a report detailing the consultation and any diagnosis or treatment plans in a timely manner. This will help provide continuity of care. Providers should also assist SHCP ADSMs in maintaining their medical records by having them sign an annual medical release form. A complete copy of the medical records, including copies of specialty and ancillary care documentation, must be provided to the service member within 30 calendar days of receiving the request. Network providers should refer to their contract for information regarding medical records copying fees reimbursement. Non-network providers may receive reimbursement for medical records copying fees by sending the charges on a standard invoice or statement to:

TRICARE West Region Claims Department
P.O. Box 7064
Camden, SC 29021 -7064

See the Claims Processing and Billing Information section of this Handbook for SHCP claims submission information.

Contact the case management staff at 888-571-5232 for assistance or any questions.

Other Health Insurance and Third-Party Liability
UnitedHealthcare will not apply OHI or third-party liability processing procedures to SHCP claims for outpatient active duty and non-TRICARE-eligible beneficiaries.

See the Claims Processing and Billing Information section of this Handbook for claims submission information. For more information regarding the SHCP, visit myTRICARE.com > Learn about TRICARE.
Transitional Health Care Benefits
TRICARE offers the following program options for beneficiaries separating from active duty.

Transitional Assistance Management Program (TAMP)
TAMP offers qualifying armed services members and their family members transitional health care benefits when the sponsor separates from active duty service.

The beneficiary may be enrolled in TRICARE Prime or may be using TRICARE Standard and TRICARE Extra. All referral, authorization, and claims-filing processes continue to apply. TRICARE Prime rules and access standards are the same during TAMP coverage. These beneficiaries must have valid uniformed services ID cards or CACs. See the TRICARE Eligibility section of this Handbook for information about verifying eligibility.

Note: TAMP deductibles do not apply to National Guard and Reserve members during this period. Additionally, LOD care is not covered under TAMP. For more information regarding Line-of-Duty Care, see Line-of-Duty Care for National Guard and Reserve Members section.

For more information on TAMP, visit tricare.mil/tamp.

Transitional Care for Service-Related Conditions (TCSRC)
The TCSRC program extends TRICARE coverage for qualified former ADSMs who are 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
• Validated by a DoD physician
• Able to be resolved within 180 days, as determined by a DoD physician, from the date the condition is validated

The TCSRC benefit covers care only for the specific service-related condition; preventive and health maintenance care is not covered. TCSRC beneficiaries may seek care at MTFs or from TRICARE-authorized civilian providers if MTF care is not available. There are no copayments or cost-shares under TCSRC, and providers must submit claims in the same manner as other West Region claims are submitted. The TCSRC benefit is available worldwide.

For more information on TCSRC, visit tricare.mil/tcsrc.

Continued Health Care Benefit Program (CHCBP)
CHCBP provides transitional benefits for a specified period of time (18–36 months) to former service members and their families, some unremarried former spouses, and emancipated children (living on their own) who enroll and pay quarterly premiums.

DoD has contracted with Humana Military Healthcare Services, Inc. (Humana Military) to administer the CHCBP. Humana Military issues beneficiaries a CHCBP ID card (shown in Figure 5.8 below) after enrollment is completed.

This card is different from a uniformed services ID card or a CAC. All questions regarding CHCBP eligibility verification can be addressed through Humana Military’s website at Humana-Military.com or by calling 800-444-5445.

Note: UnitedHealthcare is unable to provide assistance with CHCBP inquiries.

Continued Health Care Benefit Program Coverage
The benefits available under CHCBP are similar to TRICARE Standard and TRICARE Extra, and although it is not part of TRICARE Standard or Extra, it operates under most of the same rules. When providing care under CHCBP, providers are not required to use or coordinate with MTFs because CHCBP beneficiaries are not eligible to receive military care or use MTFs (except for emergency care).

Referrals and Authorizations
All CHCBP referrals and authorizations are coordinated through Humana Military. Providers must seek authorization for care that is deemed medically necessary. Medical necessity rules follow TRICARE Standard and TRICARE Extra guidelines. Use one of the following numbers to coordinate CHCBP referrals and/or authorizations:

<table>
<thead>
<tr>
<th>Phone</th>
<th>800-444-5445</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax</td>
<td>877-270-9113</td>
</tr>
</tbody>
</table>
Note: Humana Military’s prior authorization requirements are not the same as those for UnitedHealthcare. Humana Military has contracted with PGBA for CHCBP claims processing. See the Claims Processing and Billing Information section of this Handbook for more information about filing CHCBP claims.

Medical Coverage
TRICARE covers most inpatient and outpatient care that is medically necessary and considered proven. However, there are special rules or limits on certain types of care, while other types of care are not covered at all. Beneficiary liability for covered services is determined by the program option the beneficiary is using: TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TRICARE Standard and TRICARE Extra, TRICARE For Life (TFL), TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Young Adult (TYA). See the TRICARE Program Options section of this Handbook for specific beneficiary liability information.

This section provides information on covered services and specific details about some of the more complex benefits.

This section is not all-inclusive.

For additional information or answers to specific questions about TRICARE-covered services, contact UnitedHealthcare at 877-988-9378, or review the TRICARE Policy Manual, TRICARE Reimbursement Manual, and TRICARE Operations Manual online at manuals.tricare.osd.mil. Additionally, you may review tricare.mil for regular articles about benefits and program changes.

Some MTFs may offer services or procedures that are not covered by TRICARE. Beneficiaries should contact their local MTFs for more information about these services. Additionally, R&SMSO-GL may authorize services for ADSMs that are not usually covered TRICARE benefits. As long as an authorization is in place in these specific instances, providers will be paid for providing non-covered services to beneficiaries according to TRICARE guidelines.

Covered Services
Subject to applicable coverage rules and limits, TRICARE covers outpatient services such as:

- Routine office visits
- Outpatient office-based medical and ambulatory (same-day) surgical care, unless the procedure code is specifically noted as being on the “Inpatient Only” list, which specifies that procedures must be performed in an inpatient setting.
- Consultation, diagnosis, and treatment by a specialist
- Allergy tests and treatment
- Rehabilitation services (e.g., physical therapy, speech-language pathology, occupational therapy)
- Medical supplies used within the office, including casts, dressings, and splints
- Certain diagnostic radiology and ultrasound, diagnostic nuclear medicine, pathology and laboratory services, and cardiovascular studies
Subject to applicable coverage rules and limits, TRICARE covers medically necessary inpatient services, such as:

- Hospitalization in a semiprivate room (or in special care units when medically necessary) with general nursing, hospital service, and inpatient physician and surgical services
- Meals, including special diets
- Drugs and medications during an inpatient stay
- Operating and recovery room
- Anesthesia
- Laboratory tests
- X-rays and other radiology services
- Necessary medical supplies and appliances
- Blood and blood products

The services listed below will be discussed in more detail:

- Adjunctive dental care
- Ambulance services
- Clinical preventive services
- Durable medical equipment (DME)
- Emergency care
- Home health care
- Hospice care
- Injectable medications requiring prior authorization by UnitedHealthcare
- Maternity care
- Skilled nursing facility (SNF) care
- Urgent care
- Vision care

Refer to the Prior Authorization List at UCHMilitaryWest.com > Providers > Referrals and Prior Authorizations for a list of the codes that require an authorization. Secure website users may also access the West Region Benefit Lookup tool to search additional information by Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code.

Inpatient and outpatient behavioral health care is also covered. See the Behavioral Health Care Services section of this Handbook for details about covered behavioral health care services.

**Adjunctive Dental Care**

The TRICARE medical benefit covers adjunctive dental care. In most cases, adjunctive dental care is medically necessary in the treatment of an otherwise-covered medical (not dental) condition; is an integral part of the treatment of such medical condition; or is required in preparation for, or as the result of, dental trauma that may be or is caused by medically necessary treatment of an injury or disease.

These are some examples of adjunctive dental procedures that TRICARE may cover:

- Removal of teeth and tooth fragments to treat and repair facial trauma resulting from an accidental injury
- Total or complete ankyloglossia (tongue-tie) to alleviate difficulty swallowing or speaking (partial ankyloglossia is not covered.)
- Dental or orthodontic care that is directly related to the medical and surgical correction of a severe congenital anomaly
• Dental care in preparation for, or as a result of, in-line radiation therapy for oral or facial cancer

• Treatment of acute (not chronic) myofascial pain/TMJ pain; care of these patients is subject to some additional restrictive guidelines:
  › Treatment of this syndrome may be considered a medical problem only when it involves immediate relief of pain.
  › Emergency treatment may include initial radiographs, up to four office visits, and the construction of an occlusal splint, if necessary to relieve pain and discomfort.
  › Treatment beyond four visits, or any repeat episodes of care within a period of six months, must receive individual consideration and be documented by the provider of services.
  › Occlusal equilibration and restorative occlusal rehabilitation are specifically excluded for myofascial pain dysfunction syndrome.

The TRICARE health care benefit does not cover non-adjunctive dental care, which refers to any routine, preventive, restorative, prosthodontic, periodontic, or emergency dental care that is not related to a medical condition. TRICARE may, however, cover medically necessary institutional and general anesthesia services in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental, or physical disabilities, or for pediatric patients age 5 or younger. TRICARE beneficiaries may receive non-adjunctive dental services through military dental treatment facilities (DTFs) and through one of three TRICARE dental programs (i.e., ADDP, TDP, or TRDP), if enrolled. Refer to the TRICARE Program Options section of this Handbook for TRICARE dental options.

The following are examples of dental care that the TRICARE medical benefit does not cover when the care is not related to, or caused by, an underlying medical condition or congenital abnormality:

• Treatment of dental caries and periodontal disease
• Emergency room visits for dental conditions (i.e., dental pain)
• Extraction of teeth, including impacted wisdom teeth
• Provision of implants, crowns, dentures, and bridges

Care for accidental injury to the teeth alone is not considered adjunctive dental care and is not covered by the TRICARE medical benefit, whereas care for injury to the teeth resulting from the treatment of a medical condition, such as removing teeth fragments in order to treat facial trauma, is covered.

In some instances, hospital services and supplies may be covered for a patient who requires a hospital setting for non-covered, non-adjunctive dental care. For instance, a child with congenital heart disease and extensive dental disease who needs anesthesia during care may require care in a hospital to ensure hemodynamic stability during the treatment.

There are several important considerations concerning this benefit. First, medical documentation that establishes the severity of the patient’s underlying medical condition must be submitted. (A primary care manager [PCM] or specialty care provider may need to submit this information.) Secondly, acute anxiety, behavioral issues, need for extensive treatment, or need for sedation/anesthesia do not, by themselves, qualify the patient for this coverage. The patient must still have a serious underlying medical condition unless he or she is age 5 or younger, or has developmental, mental, or physical disabilities. Finally, when coverage is authorized, it is only for facility fees, medical-supply coverage, anesthesiology services, and professional medical services related to the medical condition. General anesthesia cannot be provided by the attending dentist; it must be administered by a separate anesthesiology provider, regardless of the setting in which the general anesthesia is provided. The professional dentist’s fees for the non-adjunctive dental care are not covered.

All adjunctive dental care requires prior authorization. The prior authorization process will determine if a beneficiary’s condition requires adjunctive or non-adjunctive dental care. The prior authorization requirement is waived only when essential adjunctive dental care involves a medical emergency (e.g., facial injuries resulting from a car accident).

For a more detailed list of adjunctive dental procedures that TRICARE covers, refer to the TRICARE Policy Manual, Chapter 8, Section 13.1 at manuals.tricare.osd.mil.
**Ambulance Services**

TRICARE covers ambulance services in the following circumstances:

- Emergency transport to a hospital
- Transfer from one hospital to the nearest hospital more capable of providing the required care as ordered by a physician
- Transfers between a hospital or SNF and another facility for outpatient therapy or diagnostic services ordered by a physician
- Transfers to and from a SNF when medically indicated

**Note:** Payment of ambulance transfers to and from a SNF may be included in the SNF prospective payment system.

Air or boat ambulance is only covered when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities, and the patient’s medical condition warrants speedy admission or is such that transfer by other means is contraindicated.

TRICARE does not cover ambulance services for these conditions:

- Non-emergency ambulance services used instead of a taxi service or other normal transportation means when the patient’s condition would permit use of regular transportation (Ambulance transportation is covered under the TRICARE ECHO benefit when the beneficiary is being transported to and from institutions or facilities when the beneficiary is receiving institutional care.)
- Transport or transfer of a patient primarily for the purpose of having the patient closer to home, family, friends, or a physician
- Any type of medicabs or ambicabs that function as public passenger services transporting patients to and from medical appointments

For more information about ambulance services, refer to the *TRICARE Policy Manual*, Chapter 8, Section 1.1. For more information about patient transport services, refer to the *TRICARE Policy Manual*, Chapter 2, Section 6.1 at manuals.tricare.osd.mil.

**Bariatric Surgery**

Bariatric surgery for morbid obesity is covered for TRICARE beneficiaries who meet all of the following three conditions:

1. The patient has either:
   - A body-mass index (BMI) greater than or equal to 40 kg/m2.
   - A BMI of 35-39.9 kg/m2 with one clinically significant comorbidity including, but not limited to, cardiovascular disease, type 2 diabetes mellitus, obstructive sleep apnea, Pickwickian syndrome, hypertension, coronary artery disease, obesity-related cardiomyopathy, or pulmonary hypertension.

2. The patient has completed growth (age 18 or documentation of completion of bone growth).

3. The patient has been previously unsuccessful with medical treatment for obesity. Failed attempts must be documented in the patient’s medical record.
   - Commercially available diet programs or plans, such as Weight Watchers®, Jenny Craig, or similar plans, are acceptable methods of dietary management if there is concurrent documentation of at least monthly clinical encounters with a physician. However, these diet programs are not covered by TRICARE.
   - Physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

When all of these conditions are met, TRICARE covers any of the following open or laparoscopic surgical procedures:

- Roux-en-Y gastric bypass
- Vertical banded gastroplasty
• Gastroplasty (stomach stapling)
• Adjustable gastric banding (i.e., adjustable LAP-BAND®)

TRICARE does not cover:

• Nonsurgical treatment of obesity or morbid obesity (commercial diet programs, weight-loss supplements)
• Redundant skin surgery when performed solely for the purpose of improving appearance
• Biliopancreatic bypass, gastric bubble or balloon, gastric wrapping/open banding, or sleeve gastrectomy for the treatment of morbid obesity
• Devices used for bariatric surgery not approved by the U.S. Food and Drug Administration (FDA)

Note: TRICARE only covers one bariatric surgery per lifetime. In certain medically necessary circumstances, TRICARE will also cover bariatric-revision surgery.

For more information on surgery for morbid obesity, refer to the TRICARE Policy Manual, Chapter 4, Section 13.2 at manuals.tricare.osd.mil.

Clinical Preventive Services

Preventive care is not diagnostic and includes medical procedures not related directly to a specific illness, injury, or definitive set of symptoms or obstetrical care, but rather medical procedures performed as periodic health screening, health assessment, or health maintenance visits. Certain services may be provided during acute and chronic care visits or during preventive care visits for asymptomatic individuals to maintain and promote good health.

Cancer Screenings

• Breast Cancer Screening:
  › Clinical Breast Examination: For women under age 40, a clinical breast examination may be performed during a preventive health visit. For women age 40 and older, a clinical breast examination should be performed annually.
  › Mammograms: Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15 percent or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:
    • History of breast cancer, Ductal Carcinoma In Situ, Lobular Carcinoma In Situ, Atypical Ductal Hyperplasia, or Atypical Lobular Hyperplasia
    • Extremely dense breasts when viewed by mammogram
    • Known BRCA1 or BRCA2 gene mutation*
    • First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves*
    • Radiation therapy to the chest between ages 10 and 30
    • History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes*

• Breast Screening Magnetic Resonance Imaging (MRI): Covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20 percent or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:
  › Known BRCA1 or BRCA2 gene mutation*

* Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service
• First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves*

• Radiation to the chest between ages 10 and 30

• History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes*

**Colonoscopy:** Individuals at average risk for colon cancer are covered once every 10 years beginning at age 50. Individuals at increased and high risk for colon cancer are covered as follows:

  - **Increased risk:** Once every five years for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp before age 60, or in two or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. Once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second-degree relatives.

  - **High risk:** Once every one to two years for individuals with genetic or clinical diagnoses of hereditary non-polyposis colorectal cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20 to 25 or 10 years younger than the earliest age of diagnosis, whichever is earlier.

  For individuals diagnosed with inflammatory bowel disease, chronic ulcerative colitis, or Crohn’s disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10–12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.

  **Note:** Computed tomographic colonography (CTC) is covered as a colorectal cancer screening only when an optical colonoscopy is medically contraindicated or cannot be completed due to a known colonic lesion or structural abnormality, or when other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is not covered as a colorectal cancer screening for any other indication or reason.

**Fecal occult blood testing:** Perform either guaiac-based or immunochemical-based testing of three consecutive stool samples annually starting at age 50.

**Human papillomavirus (HPV) deoxyribonucleic acid (DNA) testing:** HPV DNA testing is covered as a cervical cancer screening only when performed and billed in conjunction with a Pap smear, and only for women age 30 and older. The effective date for coverage of HPV DNA testing as a cervical cancer screening was Sept. 7, 2010.

**Oral cavity and pharyngeal cancer screening:** A complete oral cavity examination should be part of routine preventive care for adults at high risk due to exposure to tobacco or excessive amounts of alcohol.

**Proctosigmoidoscopy or sigmoidoscopy:** Individuals at average risk for colon cancer are covered once every three to five years beginning at age 50. Individuals at increased and high risk for colon cancer are covered as follows:

  - **Increased risk:** Once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives.

  - **High risk:** Annual flexible sigmoidoscopy, beginning at age 10 to 12, for individuals with known or suspected familial adenomatous polyposis.

**Prostate cancer:** Digital rectal examination and prostate-specific antigen screening annually for all men in the following categories:
› Age 50 or older
› Age 45 or older with a family history of prostate cancer in at least one other family member
› All African-American men age 45 or older regardless of family history
› All men age 40 and older with a family history of prostate cancer in two or more family members

- **Routine Pap smears:** Conduct annually starting at age 18 (or younger if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may be less often at your and the patient’s discretion, but not less than every three years.

- **Skin cancer:** Skin examination should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.

- **Testicular cancer screening:** Perform a clinical testicular physical examination annually for males ages 13–39 with history of cryptorchidism, orchiopexy, or testicular atrophy.

- **Thyroid cancer screening:** Palpation for thyroid nodules should be performed in adults with a history of upper body irradiation.

**Cardiovascular**

A cholesterol test (non-fasting) should occur once every five years beginning at age 18. Blood pressure should be tested annually for children ages 3–6 and a minimum of every two years after age six (children and adults).

**Clinical Preventive Examinations**

- **TRICARE Standard and TRICARE Extra:** A comprehensive clinical preventive examination is covered if it includes or is rendered at the same time as a covered immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening. See the individual screening services for frequency of coverage. School enrollment physicals for children ages 5–11 are covered. Annual sports and/or camp physicals are excluded.

- **TRICARE Prime:** In addition to the above, TRICARE Prime beneficiaries in each of the following age groups may receive one comprehensive clinical preventive examination without an accompanying immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening (one examination per age group): 2–4, 5–11, 12–17, 18–39, and 40–64 years. While often rendered by a PCM, clinical preventive examinations and accompanying immunization and screenings may be performed by any network provider without a referral. For screening Pap smears, mammograms, or colonoscopies, see the individual services for frequency of coverage.

**Hearing**

Preventive hearing examinations are only allowed under the well-child care benefit. All neonates should undergo audiology screening before leaving the hospital. However, if not tested at birth, all infants should undergo audiology screening before 1 month of age. Those who do not pass the audiologic screening should be tested before 3 months of age using evoked otoacoustic emission and/or auditory brainstem response testing. Evaluative hearing tests may be performed at other ages during routine examinations.

**Human Papillomavirus Vaccine**

TRICARE follows the Centers for Disease Control and Prevention (CDC) guidelines for administering the HPV vaccine. The CDC recommends the vaccine for all females ages 11–26 who have not completed the vaccine series, regardless of sexual activity or clinical evidence of previous HPV infection. Ideally, the vaccination should be given before potential exposure to HPV through sexual activity and may be given as early as age 9. After age 26, no efficacy has been established; therefore, it is not a covered benefit. HPV DNA testing is covered as a cervical cancer screening only when performed in conjunction with a Pap smear, and only for women age 30 and older.

**Immunizations**

TRICARE coverage will be extended for the age-appropriate dose of vaccines when:

- The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) for use in the United States
The ACIP-adopted recommendations have been accepted by the director of the CDC and the secretary of the U.S. Department of Health and Human Services and published in a *CDC Morbidity and Mortality Weekly Report* (MMWR).

TRICARE coverage is effective the date the recommendations are published in the MMWR. Refer to the CDC’s website at CDC.gov for a current schedule of recommended vaccines.

**Note:** Immunizations recommended specifically for travel outside the United States are not covered, except for immunizations required for ADFMs whose sponsors have permanent change-of-station orders to overseas locations. These immunizations are covered as outpatient office visits.

TRICARE covers age-appropriate doses of annual influenza vaccines based on the current influenza season CDC guidelines.

**Infectious Disease Screening**
Covered screenings for infectious diseases include hepatitis B, rubella antibodies, and HIV, and screening and/or prophylaxis for tetanus, rabies, Rh immune globulin, hepatitis B, meningococcal meningitis, and tuberculosis.

**Lead Exposure Testing**
A blood lead test during each well-child visit from ages six months–6 years is covered if the assessment of risk for lead exposure is positive based on a structured questionnaire developed for the CDC.

**Patient/Parent Education**
These education or counseling services may be rendered as part of an office visit but are not reimbursed separately:

- Accident and injury prevention
- Bereavement
- Cancer surveillance
- Dental health promotion
- Dietary assessment and nutrition
- Physical activity and exercise
- Safe sexual practices
- Stress
- Suicide-risk assessment
- Tobacco, alcohol, and substance abuse

**Shingles Vaccine**
Per CDC-recommended guidelines, TRICARE covers a single dose of the shingles vaccine Zostavax® for beneficiaries age 60 and older.

**Well-Child Care**
Well-child care (birth to age 6) includes routine newborn care; comprehensive health promotion and disease prevention examinations; vision and hearing screenings; height, weight, and head circumference; routine immunizations; and developmental and behavioral appraisal in accordance with American Academy of Pediatrics® and CDC guidelines.

**Differences in Coverage Based on Beneficiary Program Option**
Coverage for clinical preventive services varies depending on whether a beneficiary is using TRICARE Prime or TRICARE Standard and TRICARE Extra.

**TRICARE Prime:**
- Offers enhanced vision coverage (See *Vision Care* later in this section for more details.)
- Enrollees do not need referrals or prior authorizations for clinical preventive services when using network providers*

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* ADSMs must have referrals and prior authorizations before receiving clinical preventive services, except for those enrolled in TPR when care is rendered by their primary care providers.
• There is no copayment when care is received from a TRICARE network provider

TRICARE Standard and TRICARE Extra:

• Routine eye examinations only covered for ADFMs, infants, and children up to age six (See Vision Care later in this section for more details.)

• Beneficiaries may have clinical preventive services performed by TRICARE-authorized network or non-network providers

• Cost-shares and deductibles apply for some services

For more information about TRICARE-covered clinical preventive services, refer to the TRICARE Policy Manual, Chapter 7, Sections 2.1–2.2 at manuals.tricare.osd.mil.

Durable Medical Equipment (DME)

DME refers to medical equipment or supplies that your patient will need to arrest or reduce functional loss. DME must be ordered by a physician. Only MD or DO signatures are accepted. All DME with a purchase price of $150 and above requires authorization. Refer to the TRICARE and Other Health Insurance Section for OHI requirements for DME. A Certificate of Medical Necessity (CMN) is required for all DME claims with a purchase price greater than $150.00. A CMN should contain the patient’s prognosis and estimated length of medical necessity (the beginning and end date of medical need). CMNs must be updated annually.

Authorizations will satisfy the requirements for CMN for DME items costing $150-$2,000, with the exception of the items listed below that will require additional clinical information through the submission of the appropriate CMS form for authorization processing.

All DME authorization requests should contain the following information:

• Patient’s name

• Procedure Code(s)

• Diagnosis Code(s)

• Beginning and ending date equipment is needed

• Physician’s statement of prognosis

• Valid physician signature

• Signature CANNOT be a certified nurse practitioner or certified physician assistant

The items below require the information above and the completion and submission of the appropriate CMS form, as noted in the table below. The forms below can be accessed at: cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-list.html.

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A DME item over $2,000 requires proof of Medical Necessity for authorization. When submitting a request for authorization, include the required items identified in Figure 6.1 above and supporting clinical information justifying the need for the DME.

Medically Necessary Upgrades:

An upgraded item of DME, which otherwise meets the DME benefit requirement and is medically necessary, is covered if the prescription specifically states the medical reason why an upgrade is necessary. For example, the beneficiary does not have the physical strength or balance required to lift a standard walker and, therefore, one with wheels is required. Equipment lacking documentation of medical necessity for the deluxe, luxury, or immaterial feature device may have the TRICARE allowed amount
for the base model applied to the upgraded equipment, with the beneficiary responsible for the difference between the allowed amount for the base model and the provider’s billed charges.

If the beneficiary prefers to upgrade an item of DME, which otherwise meets the DME benefit requirements, the beneficiary will be solely responsible for the cost that exceeds the cost of what the government would pay for the standard equipment. The upgraded item must be within the range of services that are appropriate for the beneficiary’s medical condition (e.g., beneficiaries can upgrade from a standard manual wheelchair to a power wheelchair, when there is no medical objection from the physician, but not from a walker to a wheelchair). Refer to the Waiver of Non-Covered Services section for details regarding patient financial responsibility.

DME claims should be filed using the correct modifier(s). Examples of common modifiers are listed below:

- NU – New equipment
- RR – Rental
- UE – Used equipment

Refer to the Prior Authorization List at UHCMilitaryWest.com > Providers > Referrals and Prior Authorizations for additional DME codes that require prior authorization. UnitedHealthcare clinical staff makes determinations based on medical necessity and TRICARE guidelines.

DME guidelines specify DME that is always rented, always purchased, and rent-to-purchase options. Capped rentals can only be purchased if the beneficiary has coverage primary to the TRICARE benefit. Applicable modifiers must be billed on capped rental claims. Examples of these modifiers are as follows:

- KH – first month rental
- KI – second and third month rental
- KJ – fourth to fifteenth months rental

For more information about DME, refer to the following:

- TRICARE Policy Manual, Chapter 8, Section 2.1 at manuals.tricare.osd.mil.
- Medicare guidelines located at cms.gov > Medicare > Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule

For reimbursement purposes, DME is now defined as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Refer to the TRICARE Reimbursement Methodologies section of this Handbook for more information about DMEPOS reimbursement guidelines.

**Emergency Care**

An emergency is defined as a medical, maternity, or psychiatric condition that would lead a prudent layperson (someone with average knowledge of health and medicine) to believe that a serious medical condition exists or that the absence of immediate medical attention would result in a threat to life, limb, or sight; or when the person manifests painful symptoms requiring immediate palliative effort to relieve suffering. This includes situations where a beneficiary arrives at the emergency room with severe pain (except dental pain), or is at immediate risk of serious harm to self or others. In the case of pregnancy, the danger to the health of the woman or her unborn child must be considered. In the absence of other qualifying conditions, pain associated with pregnancy, or incipient birth after the 34th week of gestation when associated with a pregnancy, are not emergency conditions for adjudication purposes.

In the event of a life-, limb-, or eyesight-threatening emergency, the beneficiary should go, or be taken, to the nearest appropriate medical facility for care.

**Note:** Most dental emergencies, such as going to the emergency room for a severe toothache, are not a covered medical benefit under TRICARE. ADSMs receive dental care from military DTFs and, if necessary, from civilian providers through the TRICARE ADDP. Dependents may be eligible to enroll in either the TDP or the TRDP, depending on their sponsor’s status. For more information refer to TRICARE Dental Options in the TRICARE Program Options section of this Handbook.
Notify UnitedHealthcare in Case of Emergency Admissions

Providers must notify UnitedHealthcare within 24 hours of an emergency medical admission unless otherwise specified in the provider’s contract. Admissions resulting from a psychiatric emergency should be reported to UnitedHealthcare within 24 hours of the admission or the next business day after the admission, but must be reported within 72 hours of the admission. This also applies to weekend notifications. Medical/surgical and maternity admission notifications can occur by fax or phone. Providers may fax face sheets to 877-578-2738. Notification of outpatient observation is not required. Emergency psychiatric admissions may be reported by faxing a completed Inpatient Emergency Admission—Mental Health form to UnitedHealthcare:

Routine Requests –877-581-1590
Urgent Requests –877-579-8589

Home Health Care

TRICARE’s home health care benefits are similar to those covered under Medicare. To qualify for TRICARE coverage of any home health care services, the patient must meet each of the following criteria:

- Patient is confined to the home
- Services are provided under a plan of care established and approved by a physician
- Patient is under the care of the physician who approved the plan of care
- Patient needs one of the following types of services:
  - Skilled nursing care that is reasonable and necessary (as defined in the TRICARE Reimbursement Manual, Chapter 12, Section 2)
  - Psychiatric evaluation, therapy, and teaching (covered as a skilled nursing service)
  - Intermittent skilled nursing care*
  - Skilled therapy services (i.e., physical therapy, speech-language pathology, or occupational therapy)

If a patient qualifies for coverage of home health care services, TRICARE covers a limited number of hours per week of either part-time or intermittent services. All home health care must be provided by a participating home health care agency.

It is important to note that assistance with activities of daily living (e.g., washing laundry, cleaning dishes) is not part of the home health benefit. While the home health care professional may provide some assistance with basic daily living care, these tasks are not separately reimbursable and are not the primary duties while in the patient’s home.

For more information about home health care, refer to the TRICARE Reimbursement Manual, Chapter 12 at manuals.tricare.osd.mil. For home health care benefits related to the TRICARE ECHO program, refer to the TRICARE Policy Manual, Chapter 9, Section 15.1 manuals.tricare.osd.mil.

Respite Care for Active Duty Service Members (ADSMs)

TRICARE covers respite care for ADSMs who are homebound as a result of a serious injury or illness incurred while serving on active duty. The benefit provides rest for the primary caregiver caring for an injured or ill ADSM at home.

Respite care is available if the ADSM’s plan of care includes frequent interventions by the primary caregiver. “Frequent” means that more than two interventions are required during the eight-hour period per day that the primary caregiver would normally be sleeping.

Respite benefits are limited to:
- A maximum of 40 respite hours in a calendar week
- No more than five days per calendar week
- No more than eight hours per calendar day

There are no copayments, cost-shares, or dollar maximums.

* To meet the criteria for “intermittent” skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.
The respite care must be provided by a TRICARE-authorized home health agency. When UnitedHealthcare receives a request from the military services for respite care, the following occurs:

- An authorization will be entered into UnitedHealthcare’s medical management system.
- Services are authorized in 90-day increments.
- An authorization will be approved and a letter will be sent to the provider by fax or email. The beneficiary will receive a copy of the authorization letter. Both the beneficiary and the provider, when registered, may obtain immediate status of the authorization on the secure website at UHCMilitaryWest.com.

The ADSM is not required to be enrolled in the TRICARE ECHO program to receive this respite benefit. Claims are submitted to PGBA in the same manner as other West Region claims.

For additional details on the respite care benefit for ADSMs, refer to the TRICARE Operations Manual, Chapter 7, Section 3 and Chapter 18, Addendum B at manuals.tricare.osd.mil.

**Hospice Care**

TRICARE has adopted most of the provisions currently set out in Medicare’s hospice coverage benefit guidelines, reimbursement methodologies, and certification criteria for participation in the hospice program. The hospice benefit is designed to provide palliative care to individuals with prognoses of less than six months to live if the terminal illness runs its normal course. This type of care emphasizes supportive services, such as pain control and home care, rather than cure-oriented treatment.

All TRICARE beneficiaries are eligible for the hospice benefit.

TFL beneficiaries do not need hospice authorizations from UnitedHealthcare. For additional information about TFL, please visit tricare4u.com or contact Wisconsin Physicians Service (WPS), 866-773-0404.

Refer to the Claims Processing and Billing Information section of this Handbook and UHCMilitaryWest.com for other health insurance requirements.

Hospice care must be provided by a Medicare-certified hospice agency. If the hospice provider is not currently TRICARE-certified, it may download the Institutional Provider File Application form by visiting UHCMilitaryWest.com > Providers > Find A Form > Certification > Provider Certification Forms.

**Exclusions**

There is no reimbursement for room-and-board charges for a patient who is receiving hospice services in the home. Room and board is not a covered hospice benefit when a patient is placed in a facility, such as a rest home, and the care is custodial. Patients also cannot receive other TRICARE services/benefits related to the treatment of the terminal illness for which hospice care is elected unless the hospice care is formally revoked. If not revoked, no treatment for the terminal illness is covered by TRICARE unless the hospice provides the treatment or arranges for it.

**Benefit Periods**

Hospice care is provided in three benefit periods, each of which requires a separate authorization:

- First 90-day period
- Second 90-day period
- Unlimited number of 60-day periods

**Levels of Hospice Care**

There are four levels of hospice care. All four levels are approved at the time of authorization of services. The hospice provider determines which level of care is appropriate for the patient. UnitedHealthcare does not require notification when the patient moves to a different level of hospice care:

- Routine home care
- Continuous home care
- Inpatient respite care (up to five days per month)
- General hospice inpatient care
Revocation/Transfer to Another Hospice
The beneficiary may choose to revoke or end hospice services at any time. The beneficiary also may decide to re-elect hospice services at any time, but will forfeit the remaining days for the benefit period the beneficiary is in at the time the beneficiary revokes. Basic TRICARE coverage will be in effect following the revocation. The hospice must submit the patient’s signed and dated revocation form to UnitedHealthcare by fax at 877-890-8203. The beneficiary may choose to transfer to another hospice, up to one transfer during each election period. The beneficiary will stay in the current benefit period following the transfer. The hospice must submit the signed and dated transfer form, as well as the name of the hospice to which the care is transferred, to UnitedHealthcare by fax at 877-890-8203.

Hospice Referrals
To initiate a hospice referral, a provider should select a TRICARE network hospice provider (when a network provider is available) and refer the patient to the hospice provider. Once the hospice receives the referral, it will contact the beneficiary for an evaluation. TRICARE does not require an authorization for the initial hospice evaluation. However, an authorization is required to receive hospice services. Once the patient elects hospice care, the hospice will submit an authorization request to UnitedHealthcare.

Hospice Authorizations
UnitedHealthcare requires the following items to be submitted at the time of initial authorization or recertification. It is the hospice provider’s responsibility to provide the documentation to UnitedHealthcare.

For initial hospice authorization:

- Hospice providers must register for the secure provider website at UHCMilitaryWest.com. The initial hospice authorization should be submitted by fax.
- The patient hospice election form (also called hospice consent), signed and dated by the beneficiary, must be attached to the faxed request. UnitedHealthcare does not supply this form; each hospice has its own.

After printing and completing the form, providers should fax it to UnitedHealthcare at 877-890-9309. The patient hospice election form (also called hospice consent), signed and dated by the beneficiary, must be faxed with the authorization request.

For recertification, each benefit period requires a separate authorization. To request continuation of hospice services, only the hospice authorization needs to be submitted.

Hospice Claims and Reimbursement
Hospice providers should submit claims electronically when possible. For more information about claims submission, refer to the Claims Processing and Billing Information section of this Handbook or visit UHCMilitaryWest.com.

Refer to the TRICARE Reimbursement Methodologies section of this Handbook for information on reimbursement for hospice services.

Note: There are no deductibles under the hospice benefit.

For more information about hospice care, refer to the TRICARE Reimbursement Manual, Chapter 11 at manuals.tricare.osd.mil.

Injectable Medications Requiring Prior Authorization by UnitedHealthcare
Injectable medications that require physician or health care professional administration may require prior authorization by UnitedHealthcare. These medications may be dispensed in a provider’s office or by a home health agency.

Note: Covered injectable medications and prior authorization requirements may vary between TRICARE retail network pharmacies and TRICARE Pharmacy Home Delivery. If UnitedHealthcare receives a request for a drug that should be obtained through a retail pharmacy or home delivery, the requesting provider will receive a letter from UnitedHealthcare with further guidance.

Maternity Care
Maternity care involves the medical services related to prenatal care, labor and delivery, and postpartum care. Any woman eligible for TRICARE benefits can receive maternity care from the first obstetric visit through up to six weeks (42 days) after the birth of the child. Women eligible for TRICARE benefits include ADSMs, spouses of ADSMs, certain eligible former spouses, retired service members, spouses of retired service members, and TRICARE-eligible unmarried children of active duty or retired service members.
Note: A newborn grandchild of an ADSM or NADSM is not eligible for TRICARE unless the newborn is otherwise eligible as an adopted child or the child of another eligible sponsor.

Maternity Care Requests
If you are the PCM or primary care provider for a TRICARE Prime, TPR, and TPRADFM beneficiary who becomes pregnant, you are responsible for submitting a referral request for the maternity care to UnitedHealthcare. You will need to either refer the beneficiary to an obstetrician, or if you are going to manage the pregnancy, handle the required prior authorization requests throughout her pregnancy.

The approved care request will list the approved outpatient services, including the first obstetric visit through up to six weeks (42 days) after the child’s birth. Any other required outpatient services (such as a scheduled delivery, covered in the following paragraphs) that are not on the initial referral request will need additional care requests if those services are listed on the PAL.

Delivery
If the delivery is not scheduled, the beneficiary will go to the hospital or birthing facility at the time of delivery. This facility will be responsible for providing a notification of delivery to UnitedHealthcare. The PCM or OB/GYN is not required to submit an authorization request for non-scheduled deliveries.

If the delivery is a scheduled event such as induction or caesarean, and the beneficiary intends to deliver in a civilian (non-MTF) facility or birthing center, the PCM or OB/GYN needs to submit an authorization request for the delivery to UnitedHealthcare. Fax the care request for a scheduled delivery to 877-578-2738 (routine or urgent). If the patient is a TRICARE Prime beneficiary, she must use a network facility for delivery.

Notification from the facility for all deliveries is required for maternity inpatient stays (length of stay cannot be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section). Fax maternity notifications to 877-578-2738. Notifications can be made over the phone at 877-988-9378.

Covered Services

- Emergency cesarean section
- Epidural anesthesia for pain management during delivery
- Breast pumps: TRICARE covers breast pumps, breast pump supplies and breastfeeding counseling at no cost for new mothers, including mothers who adopt an infant and plan to breastfeed. Coverage is effective for purchases made on or after Dec. 19, 2014. The beneficiary must have a prescription from a TRICARE-authorized doctor, physician assistant, nurse practitioner, or nurse midwife, and can get these items before or after delivery (or adoption). Coverage information can be found at tricare.mil > Life Events > Having a Baby > Newborn and Well-Baby Care.
- Medically necessary ultrasounds (e.g., to evaluate fetal well-being, growth, gestational age, or to evaluate or rule out complications); see additional information on ultrasounds later in this section
- Services and supplies associated with prenatal, childbirth, postpartum care, and complications
- TRICARE-authorized birthing centers

Non-Covered Services

- Home uterine activity monitoring (HUAM), telephonic transmission of HUAM data, or HUAM-related telephonic nurse or physician consultation
- Lymphocyte or paternal leukocyte immunotherapy for the treatment of recurrent spontaneous fetal loss
- Off-label use of FDA-approved drugs to manage uterine contractions
- Personal comfort items, such as private rooms and televisions after delivery
- Routine ultrasounds (e.g., to determine the sex of the fetus or for patients with low complication risks); see additional information on ultrasounds later in this section
- Salivary estriol test for preterm labor
• Services and supplies related to non-coital reproductive procedures (e.g., artificial insemination)

**Note:** A current list of non-covered services can be found on the No Government Pay Procedure Code List at tricare.mil/nogovernmentpay.

**TRICARE Maternity-Related Ultrasounds**

TRICARE does not cover routine ultrasound screening. Only maternity ultrasound with a valid medical indication that constitutes medical necessity is covered by TRICARE. The professional and technical components of medically necessary fetal ultrasounds are covered in addition to the maternity global fee. The medically necessary indications include, but are not limited to, clinical circumstances that require obstetric ultrasounds to:

- Conduct a biophysical evaluation for fetal well-being
- Confirm cardiac activity
- Determine the cause of vaginal bleeding
- Diagnose or evaluate multiple gestations
- Estimate gestational age
- Evaluate a suspected ectopic pregnancy
- Evaluate fetal growth
- Evaluate maternal pelvic masses or uterine abnormalities
- Evaluate suspected hydatidiform mole
- Evaluate the fetus’ condition in late registrants for prenatal care

Per American College of Obstetricians and Gynecologists guidelines, ultrasonography should be performed only when there is a valid medical indication. A physician is not obligated to perform ultrasonography for a patient who is at low risk and has no medical indications. Some providers offer all patients routine ultrasound screening as part of the scope of care after 16–20 weeks of gestation.

**Note:** For rendering providers billing with a diagnosis of supervision of normal pregnancy, a secondary diagnosis is required to establish medical necessity of a diagnostic fetal ultrasound performed during a normal pregnancy. Otherwise, the claim will not be reimbursed. Primary prenatal care providers referring patients out to receive an ultrasound must provide the diagnosis (medical indications) to the rendering provider to justify medical necessity.

**Non-Medically Necessary Maternity Ultrasounds**

An ultrasound that does not have a valid medical indication (for example, an ultrasound to determine gender) is not covered by TRICARE, and payment may be the beneficiary’s responsibility. If the beneficiary and the rendering ultrasound provider agree to perform an ultrasound that is not considered medically necessary, the ultrasound provider may only bill the beneficiary directly under certain conditions. For more information, see “Informing Beneficiaries about Non-Covered Services” under “Provider Responsibilities” in the Important Provider Information section of this Handbook.

For more information about maternity care, refer to the TRICARE Policy Manual, Chapter 4, Section 18.1 at manuals.tricare.osd.mil.

**Skilled Nursing Facility Care**

Skilled nursing care typically is not provided in a nursing home or a patient’s home, but rather in a skilled nursing facility (SNF). A SNF is required to be Medicare-certified and must enter into a participation agreement with TRICARE. Under the SNF benefit, TRICARE covers skilled nursing care and rehabilitative (physical, occupational, and speech) therapies, room and board, prescribed drugs, laboratory work, supplies, and medical equipment. TRICARE does not cover purely custodial care.

For TRICARE to cover a patient’s admission to a SNF, the patient must have had a qualifying medical condition that was treated in a hospital for at least three consecutive days (not including day of discharge). Admission to the SNF may be covered as long as the patient is admitted within 30 days of his or her discharge from the hospital (with some exceptions for medical reasons). You will need to demonstrate the patient’s need for skilled nursing services for TRICARE to pay for the SNF care.
For more information about SNF care, refer to the TRICARE Policy Manual, Chapter 2, Section 43.1 and the TRICARE Reimbursement Manual, Chapter eight at manuals.tricare.osd.mil.

**Urgent Care**

Urgent care services are medically necessary services that are required for illness or injury that would not result in further disability or death if not treated immediately. However, this type of illness/injury does require professional attention and has the potential to develop into such a threat if treatment is delayed longer than 24 hours.

An urgent care condition could be a sprain, sore throat, or rising temperature. Beneficiaries enrolled in TRICARE Prime, TPR, and TPRADFM should contact their PCMs/primary care providers or UnitedHealthcare before receiving urgent care. TRICARE Prime beneficiaries must receive referrals from their PCMs. If they do not receive a referral, the claim may be paid under the point-of-service option.

- A PCM should use the Primary Urgent Care Episode of Care (EOC) to populate services and units on a referral for Urgent Care Center services. (See UHCMilitaryWest.com > Providers > Find a Form > Medical-Surgical Referrals & Authorizations > EOC Table).
- The Rendering Provider section for an urgent care center services referral should be populated with “Have a provider assigned based on specialty”.

**Vision Care**

Routine and comprehensive eye examinations for evaluation of the eyes not related to another medical or surgical condition may be covered by TRICARE.

TRICARE’s vision coverage varies based on beneficiary category and program option.

**Active Duty Service Members (ADSMs)**

TRICARE Prime ADSMs must receive all vision care at MTFs unless specifically referred to network providers, or to non-network providers if network providers are not available. TPR ADSMs may obtain periodic eye examinations from network providers without authorization as needed to maintain fitness-for-duty status.

**Active Duty Family Members (ADFMs)**

ADFMs are covered for one eye examination every twelve months, regardless of program option (e.g., TRICARE Prime, Standard and Extra and TRICARE Reserve Select). TRICARE Prime ADFMs (including TPRADFM), must use a network optometrist or ophthalmologist, while TRICARE Standard, Extra and TRS ADFMs may use any TRICARE-authorized optometrist or ophthalmologist (network or non-network).

**Retired Service Members, Their Dependents, and Others**

Retired service members, their dependents, and others who are enrolled in TRICARE Prime are covered for eye examinations under TRICARE Prime’s clinical preventive services benefit for one routine eye examination every two years by a network optometrist or ophthalmologist.

For retired service members, their dependents, and others using TRR, TRICARE for Life, TRICARE Standard, or TRICARE Extra, there is no vision coverage provided after age 6. Vision care for infants and children up to age 6 is covered under the well-child benefit.

**TRICARE Well-Child Vision Benefit for Infants and Children up to Age 6**

Vision care coverage is provided under the TRICARE well-child benefit for all TRICARE-eligible infants and children up to age 6, regardless of program option. See Figure 6.2 for coverage details.
TRICARE Well-Child Vision Care Coverage

<table>
<thead>
<tr>
<th>Beneficiary</th>
<th>Coverage</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td>One eye and vision screening at birth and six months</td>
<td>Primary care physician (e.g., pediatrician, family practitioner)</td>
</tr>
<tr>
<td>ADFM Children (ages 3–6) TRICARE Prime</td>
<td>One routine eye examination every 12 months</td>
<td>Network optometrist or ophthalmologist</td>
</tr>
<tr>
<td>ADFM Children (ages 3–6) TRICARE Standard</td>
<td>One routine eye examination every 12 months</td>
<td>Any TRICARE-authorized optometrist or ophthalmologist (network/non-network)</td>
</tr>
<tr>
<td>Non-ADFM Children (ages 3–6) TRICARE Prime</td>
<td>One routine eye examination every two years</td>
<td>Network optometrist or ophthalmologist</td>
</tr>
<tr>
<td>Non-ADFM Children (ages 3–6) TRICARE Standard</td>
<td>One routine eye examination every two years</td>
<td>Any TRICARE-authorized optometrist or ophthalmologist (network/non-network)</td>
</tr>
</tbody>
</table>

Eyeglasses, Contact Lenses, and Implantable Lenses

ADSMs are covered for eyeglasses at MTFs at no cost. To obtain eyeglasses or contact lenses outside of the MTF, ADSMs should contact the Naval Ophthalmic Support and Training Activity at www.med.navy.mil/sites/nostra or by phone at 757-887-7600.

For all other TRICARE beneficiaries, contact lenses or eyeglasses are only cost-shared with prior authorization for treatment of infantile glaucoma, keratoconus, dry eyes when normal tearing is inadequate or absent, corneal irregularities other than astigmatism, or loss of human lens function resulting from eye surgery or congenital absence.

Benefits are limited to only one set of implantable lenses required to restore vision. A set may include a combination of both implantable lenses and eyeglasses when the combination is necessary to restore vision. If there is a prescription change related to the qualifying eye condition, a new set may be cost-shared.

Replacement lenses for those that are lost, have deteriorated, or have become unusable due to physical growth are not covered. Adjustments, cleanings, and repairs of eyeglasses are not covered.

Other

Medically necessary eye examinations are covered for all categories of TRICARE beneficiaries. TRICARE Prime beneficiaries need prior authorization for medically necessary visits if they are not performed at MTFs.

Diabetic beneficiaries enrolled in TRICARE Prime are covered for an eye examination each year, regardless of their sponsor’s military status. There is no copayment for these examinations.

For more information about TRICARE’s vision coverage, refer to the TRICARE Policy Manual, Chapter 7, Sections 2.1 and 2.2 at manuals.tricare.osd.mil. For more information on ophthalmological services related to a medical or surgical condition or to the medical or surgical treatment of a covered injury or illness, refer to the TRICARE Policy Manual, Chapter 7, Section 6.1 at manuals.tricare.osd.mil.

Limitations and Exclusions

The following is a list of medical/surgical services generally not covered under TRICARE or covered with significant limitations.

This list is not all inclusive. For more information, visit tricare.mil.

Services or Procedures with Significant Limitations

The following listed services are covered with significant limitations:

Abortions: Abortions are only covered when the life of the mother would be endangered if the fetus was carried to term, or the pregnancy is the result of rape or incest. The attending physician must certify in writing that the abortion was performed because of one of the above criteria. Medical documentation must be provided. MTFs may not be able to provide such services based upon limited capabilities (e.g., education, training, experience) of staff and facilities.

Breast pumps: TRICARE covers breast pumps, breast pump supplies and breastfeeding counseling at no cost for new mothers, including mothers who adopt an infant and plan to breastfeed. Coverage is effective for purchases made on or after Dec. 19, 2014. The beneficiary must have a prescription from a TRICARE-authorized doctor, physician assistant, nurse practitioner, or nurse midwife, and can get these items before or after delivery (or adoption). Coverage information can be found at tricare.mil > Life Events > Having a Baby > Newborn and Well-Baby Care.
Cardiac and pulmonary rehabilitation: Both are covered only for certain indications. Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings is excluded.

Chiropractic care: Coverage is limited to ADSMs and is only available at specific MTFs under the Chiropractic Care Program. For more information, visit tricare.mil/chiropractic.

Cosmetic, plastic, or reconstructive surgery: Cosmetic, plastic, or reconstructive surgery is only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement after cancer surgery, or for breast reconstruction after cancer surgery.

Cranial orthotic device or molding helmet: Cranial orthotic devices are covered only for postoperative use for infants (3–18 months old) who have undergone surgical correction of craniosynostosis and have moderate-to-severe residual cranial deformities. TRICARE does not cover devices and helmets for treatment of nonsynostotic positional plagiocephaly or for the treatment of craniosynostosis before surgery.

Dental anesthesia and facility charges: Medically necessary institutional and general anesthesia services may be covered to safeguard a patient’s life or in conjunction with non-covered or non-adjunctive dental treatment for patients with developmental, mental, or physical disabilities or for pediatric patients age 5 or younger.

Dental care and dental X-rays: Both are covered only for adjunctive dental care.

Diagnostic genetic testing: Diagnostic genetic testing is covered only to confirm a clinical diagnosis that is already suspected based on a patient’s symptoms. Services should be billed using the appropriate Evaluation and Management codes. Refer to the TRICARE Policy Manual, Chapter 6, Section 3.1. For antepartum services, refer to the TRICARE Policy Manual, Chapter 4, Section 18.2 at manuals.tricare.osd.mil.

Education and training: Education and training are only covered under the TRICARE ECHO program and diabetic outpatient self-management training services. Diabetic outpatient self-management training services must be performed by programs approved by the American Diabetes Association®, as evidenced by a Certificate of Recognition.

Eyeglasses or contact lenses: See Vision Care earlier in this section.

Food, food substitutes and supplements, or other nutritional supplements: Food and food substitutes are not covered. Nutritional therapy may be covered when medically justified as the primary source of nutrition (e.g., enteral or parenteral nutrition therapy).

Hearing aids: Hearing aids and certain repairs are covered only for ADFMs who meet specific hearing-loss requirements. Hearing aids are not covered for retired service members, their families, or others.

Radiology: Certain radiologic examinations, and PET scans are not covered when TRICARE or the CDC has determined they are unproven, (e.g., PET scans for senile dementia, or certain types of cancer staging, etc.).

Shoes, shoe inserts, shoe modifications, and arch supports: Shoes and shoe inserts are covered only in very limited circumstances. Orthopedic shoes may be covered when they are a permanent part of a brace. For individuals with diabetes, extra-depth shoes with inserts or custom-molded shoes with inserts may be covered. For information on orthotics, refer to the TRICARE Policy Manual, Chapter 8, Section 3.1 at manuals.tricare.osd.mil.

Vitamins: Vitamins or minerals are not covered, unless used as a specific treatment of a medical condition.

Exclusions
The following services are excluded under any circumstances. This list is not all inclusive. Visit tricare.mil/nogovernmentpay for more information.

- Acupuncture (may be offered at some MTFs and approved for certain ADSMs, but is not covered for care by civilian providers)
- Alterations to living spaces
- Artificial insemination
- Autopsy services or postmortem examinations
- Birth control (nonprescription)
• Bone marrow transplants for treatment of ovarian cancer
• Camps or retreats (e.g., weight loss)
• Care or supplies furnished or prescribed by an immediate family member
• Diagnostic admission
• Experimental or unproven procedures
• Foot care (routine)
• Hair transplants
• Intensive Outpatient Program (IOP) for behavioral health conditions are excluded by TRICARE policy for all TRICARE members with the exception of ADSMs
• Laser/LASIK/refractive corneal surgery
• Learning disability treatment or therapy
• Naturopaths
• Non-surgical treatment of obesity or morbid obesity

Behavioral Health Care Services

This section will assist you with specific behavioral health care policies under the TRICARE program. All of the behavioral health forms referred to in this section can be found at UHCMilitaryWest.com > Providers > Find a Form > Behavioral Health.

TRICARE covers services delivered by qualified, TRICARE-authorized behavioral health care providers practicing within the scope of their licenses; to diagnose and/or treat behavioral health components of an otherwise diagnosed medical or psychological condition.

The behavioral health care outpatient network consists of licensed outpatient providers, such as psychiatrists and other physicians, psychologists, social workers, marriage and family therapists, certified psychiatric nurse specialists, and certified mental health counselors. For more information, see Visits to Supervised Mental Health Counselors or Pastoral Counselors later in this section.

The TRICARE behavioral health inpatient network consists of hospitals, inpatient psychiatric units, Partial Hospitalization Programs (PHPs), Residential Treatment Centers (RTCs) and Substance Use Disorder Rehabilitation Facilities (SUDRFs).

Determining Eligibility

Providers who are registered on the secure website can check eligibility at UHCMilitaryWest.com or myTRICARE.com. For information on registering, see UHCMilitaryWest.com > Providers > Education and Guides for registration instructions.

Behavioral Health Referral and Authorization Requirements

Providers should submit prior authorization requests via fax for all behavioral health services; online authorization services are not available. Providers should download the most current version of the appropriate form found on UHCMilitaryWest.com, under the “Find a Form” link, and fax the completed form to the appropriate number located at the bottom of the form (e.g., for outpatient therapy complete the Outpatient Treatment Request form):

Routine Requests – 877-581-1590
Urgent Requests – 877-579-8589

Prior authorization requirements are listed below for each beneficiary category. In addition to these requirements, note that prior authorization is not required for emergency behavioral health inpatient admissions. Admissions resulting from a psychiatric emergency should be reported to UnitedHealthcare within 24 hours of the admission or the next business day after the admission, but must be reported within 72 hours of the admission. UnitedHealthcare will conduct a clinical review for continuation of inpatient behavioral health services and authorize additional days, based on medical necessity.
**Active Duty Service Members**

ADSMs must have referrals and prior authorizations from their PCMs (or authorization from their SPOC if enrolled in TPR), and authorization from UnitedHealthcare for any nonemergency behavioral health care services received from civilian network or non-network providers (except as provided under TPR regulations, if applicable). ADSMs are not eligible for the initial eight self-referred visits, as described in the following section.

**Active Duty Family Members in TRICARE Prime and TRICARE Prime Remote**

Beneficiaries enrolled in TRICARE Prime (except ADSMs) and TPRADFM may see a network provider authorized under TRICARE regulations to see patients independently for the first eight self-referred routine outpatient mental health care services per FY, for a medically diagnosed and covered condition without a PCM referral or authorization from their regional contractor. Independent behavioral health providers generally include psychiatrists or other physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, and certified marriage and family therapists. Visits beyond the initial eight self-referred visits require prior authorization from UnitedHealthcare.

For more information, see *Visits to Supervised Mental Health Counselors or Pastoral Counselors* later in this section. **Note:** The first eight self-referred routine outpatient mental health visits only apply to follow-up visits that are related to a diagnosed behavioral condition. The initial Diagnostic Interview (90791 or 90792) does not count against the first eight visits. Office visits for psychotropic pharmacologic management are routine medical services and do not count against the initial eight visits for psychotherapy.

Upon the first visit, providers, if registered, may check eligibility at UHCMilitaryWest.com or myTRICARE.com. It is important to note that the initial eight visits per fiscal year are per beneficiary, not per provider. Ask the beneficiary if he or she has received previous behavioral health care. Providers do not need to “register” care or obtain referrals from UnitedHealthcare to document the initial eight outpatient visits. Claims for these initial eight outpatient visits will be processed without authorization. ADSMs may not self-refer for behavioral health care outside of the MTF.

After the first eight self-referred routine outpatient mental healthcare visits, prior authorization is required. Servicing providers must submit authorization requests by fax, and must complete an *Outpatient Treatment Request* form and fax it to 877-581-1590 for routine requests, or 877-579-8589 for urgent requests. The request will be reviewed to determine whether continuing care meets TRICARE Policy, Optum Level of Care Guidelines, VA/DoD Clinical Guidelines, and industry best practices. No additional sessions are authorized until the treatment request is reviewed.

Additionally, the following behavioral health care services require prior authorization for beneficiaries using TRICARE Prime and TPRADFM:

- Electroconvulsive therapy (ECT) rendered as an outpatient service
- Comprehensive Autism Care Demonstration (CADC) for ADFM and NADFM
- Medication management exceeding two visits a month
- Nonemergency inpatient admissions for substance use disorder or behavioral health care services
- Non-network provider services
- Partial hospitalization programs (PHPs) (Full day or half-day may be authorized utilizing a per diem contracted rate. Multiple changes in a single day for outpatient group therapy (90853) may not be delivered)
- Psychoanalysis
- Psychological/neuropsychological testing
- Residential treatment center (RTC) programs

**Non-ADSM Beneficiaries Using TRICARE Standard and TRICARE Extra, TRICARE Reserve Select, TRICARE Retired Reserve, or TYA Standard**

Beneficiaries using TRICARE Standard and TRICARE Extra benefits, (including TRS, TRR, or TYA Standard), may see a provider authorized under TRICARE regulations to see patients without a referral from a PCM for the first eight outpatient psychotherapy services per fiscal year for a medically diagnosed and covered psychotherapy condition. Independent behavioral health providers generally include psychiatrists or other physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social
workers, certified marriage and family therapists, and certified mental health counselors. Visits beyond the initial eight self-referred visits require prior authorization from UnitedHealthcare. The Diagnostic Interview (90791 or 90792) does not count against the initial eight visits in a fiscal year.

For more information, see Visits to Supervised Mental Health Counselors or Pastoral Counselors later in this section.

TRICARE Standard and TRICARE Extra, TRS, and TRR beneficiaries are encouraged to obtain care from TRICARE network providers, which reduces their out-of-pocket expenses.

Upon the first visit, providers, if registered, may check eligibility at UHCMilitaryWest.com or call 877-988-9378 for eligibility verification or other questions. It is important to note that the first eight visits are per beneficiary, not per provider. Ask the beneficiary if he or she has received previous behavioral health care not including the Diagnostic Interviews (90791 or 90792).

After the first eight self-referred routine outpatient mental healthcare visits, prior authorization is required. Servicing providers must submit authorization requests by fax, and must complete an Outpatient Treatment Request form and fax it to 877-581-1590 for routine requests, or 877-579-8589 for urgent requests. The request will be reviewed to determine whether continuing care meets TRICARE Policy, Optum Level of Care Guidelines, VA/DoD Clinical Guidelines, and industry best practices. No additional sessions are authorized until the treatment request is reviewed.

Additionally, the following behavioral health care services require prior authorization:

- Electroconvulsive therapy (ECT) rendered as an outpatient service
- Comprehensive Autism Care Demonstration (CACD) benefit for ADFM & NADFM
- Medication management exceeding two visits a month
- Nonemergency inpatient admissions for substance use disorder or mental health care services
- Non-network provider services
- Partial hospitalization programs (PHPs)
- Psychoanalysis
- Psychological/neuropsychological testing
- Residential treatment center (RTC) programs

Beneficiaries Using Medicare and TRICARE

Beneficiaries using Medicare as their primary payer are not required to obtain referrals or prior authorization from UnitedHealthcare for inpatient or outpatient behavioral health care services. These beneficiaries should follow Medicare rules for services requiring authorization. They may self-refer to any network or non-network provider who accepts Medicare. See the How TRICARE For Life Works section of this Handbook for more information about TRICARE and Medicare.

Visits to Supervised Mental Health Counselors or Pastoral Counselors

Physician supervision means the physician provides the overall medical management of the case. The referring physician does not have to be physically located on the premises of the provider to whom the referral is made.

To assure appropriate case management, coordination must be made with the referring physician on an ongoing basis. Communication with the referring provider is an indication of medical management. This is a statutory and regulatory TRICARE program requirement that cannot be altered or waived.

The counselor must keep a copy of the referral in the patient’s chart. When filing a claim, the counselor must indicate the referring physician’s name in Box 17/17a/17b of the Form1500 to certify that he or she reported (or will report), in writing, treatment results to the referring physician, as requested.

Due to the similarity of the requirements for licensure, certification, experience, and education, pastoral counselors may elect to be authorized as either pastoral counselors or certified marriage and family therapists. Pastoral counselors who elect to be authorized as certified marriage and family therapists do not require physician referrals and supervision.
TRICARE Certified Mental Health Counselor (TCMHC)
Beginning Jan. 1st, 2017, a TCMHC must be licensed for independent practice in mental health counseling and must also meet one of the following requirements:

1. Has passed the National Clinical Mental Health Counselor Examination (NCMHCE) and possesses a master’s or higher-level degree from a mental health counseling program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and have a minimum of two years post-master’s degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervisions.

OR

2. Possesses a master’s or higher-level degree from a mental health counseling program of education and training accredited by CACREP and has passed the National Counselor Examination (NCE); or possesses a master’s or higher level degree from a mental health counseling program of education and training accredited by CACREP or from an educational institution accredited by a Regional Accrediting Organization recognized by the Council for Higher Education and Accreditation and has passed the NCMHCE have a minimum of two years post-master’s degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervisions.

For additional information and the full policy, please see the TRICARE Policy Manual Chapter 11, Section 3.11.

UnitedHealthcare Behavioral Health Portal
The UnitedHealthcare Behavioral Health Portal found on UHCMilitaryWest.com provides self-service information and resources for all West Region TRICARE beneficiaries and providers. In addition, we have a dedicated page providing links to Clinical Training from the Defense Centers of Excellence (DCoE) and Center for Deployment Psychology, VA/DoD Practice Guidelines and Condition Support information and tools all designed to support the advancement of evidence based guidelines in service to ADSMs and their families.

Outpatient Services
Outpatient Psychotherapy
Outpatient psychotherapy is a TRICARE-authorized benefit when it is determined to be medically or psychologically necessary for treatment of covered mental health components of an otherwise diagnosed medical or psychological condition. Benefits are payable for services when rendered in the diagnosis or treatment of a covered behavioral health disorder by an authorized, qualified behavioral health care provider practicing within the scope of his or her license. The following services are available for outpatient psychotherapy:

- Individual psychotherapy typically 45-50 minutes per session, up to 60 minutes when clinically indicated
- Family or conjoint psychotherapy (session not to exceed 90 minutes but may extend to 180 minutes for crisis intervention)
- Group psychotherapy (session not to exceed 90 minutes and billed once in a single day)
- Crisis intervention (individual psychotherapy session not to exceed 120 minutes; family or conjoint psychotherapy session not to exceed 180 minutes)
- Collateral visits
- Psychoanalysis*

Outpatient psychotherapy is limited to a maximum of two psychotherapy sessions per week in any combination of individual, family, collateral, or group sessions. The following frequency limitations apply to outpatient psychotherapy:

- A provider will be allowed one psychiatric Diagnostic Interview Examination (90791 or 90792) per beneficiary, per year without authorization.
- If more than one diagnostic interview is needed within the same benefit period, prior authorization must be

* Psychoanalysis requires prior authorization from UnitedHealthcare Military & Veterans.
requested by fax using the *Outpatient Treatment Request* form (benefit period is based on the FY).

- A provider cannot bill for more than two sessions per calendar week (Sunday–Saturday) without prior authorization.
- Two psychotherapy sessions may not be combined to circumvent the frequency limitation criteria (e.g., 30 minutes on one day may not be added to 20 minutes on another day and counted as one session).
- When multiple sessions of the same type are conducted on the same day (e.g., two individual sessions or two group sessions), only one session is reimbursed. **Note:** A collateral session may be conducted on the same day as another allowable procedure when the beneficiary receives individual or group therapy.

**Wait Times and Access Standards**

UnitedHealthcare expects that beneficiaries will generally have no more than a 30 minute wait time for their appointment in your office. In addition, any rescheduling of an appointment must occur in a manner that is appropriate for the beneficiary’s health care needs and ensures continuity of care consistent with good professional practice.

**Psychological and Neuropsychological Testing**

Psychological and neuropsychological testing requires prior authorization for outpatient settings. Prior authorizations are not required for inpatient settings as long as those services do not exceed the benefit limit of six hours for psychological testing or 10 hours for neuropsychological testing and are consistent with accepted application for evaluation.

Providers should submit their prior authorization requests by fax, using the *Preauthorization for Psychological/Neuropsychological Testing* form. When completing the form, a provider may request an initial evaluation in conjunction with testing. The initial evaluation does not count toward the initial eight self-referred outpatient visits.

Psychological testing must be medically necessary, for a covered diagnosis, and performed in conjunction with otherwise-covered psychotherapy. Medical necessity must be established prior to the actual testing (i.e., there must be either a diagnosis or provisional diagnosis of a behavioral health disorder, and the testing must be appropriate for the diagnosis).

Psychological testing and assessment is limited to six hours per FY. However, additional hours may be approved on a case-by-case basis. Neuropsychological testing and assessment is limited to 10 hours per FY, based on industry standards and practice to avoid excessive reviews.

TRICARE does not cover the following psychological and neuropsychological testing:

- Psychological testing and assessment as part of an assessment for academic placement (including all psychological testing related to educational programs, issues, or deficiencies)
- Psychological testing for job placement
- Psychological testing for child-custody disputes
- Psychological testing done for general screening (in the absence of specific symptoms of a covered mental disorder) to determine if individuals being tested are suffering from a behavioral health disorder
- Teacher and parental referrals for psychological testing
- For the Reitan-Indiana battery when administered to a patient under age 5 and for self-administered tests to a patient under age 13
- Testing to determine whether a beneficiary has a learning disability if the primary or sole basis for the testing is to assess for a learning disability
- Testing related to diagnosed specific learning disorders or learning disabilities (encompasses reading disorder [also called dyslexia], mathematics disorder, disorder of written expression, and learning disorder not otherwise specified)

**Note:** Testing for a patient in an RTC or PHP is included in the payment rate and cannot be separately reimbursed. Also, payment billed by an individual professional provider not employed by or under contract with the RTC or PHP is included in the payment rate.
Medication Management
Medication management is covered when provided as an independent procedure and rendered by a TRICARE-certified provider practicing within the scope of his or her license. TRICARE pays for up to two medication management visits per month without prior authorization. These visits do not count against the eight self-referred routine mental health outpatient visits. Prior authorization is required for medication management sessions exceeding two visits per month.

When a provider is performing medication management along with therapy, prior authorization is required. The provider must submit an authorization request by fax and submit an Outpatient Treatment Request form to UnitedHealthcare to obtain this prior authorization, unless the sessions fall within the initial eight self-referred outpatient visits.

Note: ADSMs require referrals and authorizations for all civilian network services.

Electroconvulsive Therapy
ECT is covered when determined to be medically necessary. Prior authorization is required for ECT when rendered as an outpatient. No prior authorization is required when administered as part of an authorized inpatient course of treatment. To be considered for payment, providers must request prior authorization for all ECT components (the facility, the psychiatrist, and the anesthesiologist). A Preauthorization for Electroconvulsive Therapy (ECT) form must be submitted to UnitedHealthcare for approval. At this time, an online profile for ECT is not available. Inpatient ECT is included in the hospital’s inpatient payment.

Outpatient Mental Health Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details (In all instances a covered condition as defined by DHA policy is required)</th>
<th>Prior Authorization</th>
<th>Frequency Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Diagnostic Interview Examination</td>
<td>• Covered</td>
<td>• Not required (unless provider requests more than one per FY (Oct. 1– Sept. 30))</td>
<td>• One evaluation per beneficiary per provider per FY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Two per beneficiary per FY is allowed if performed by two different providers.</td>
</tr>
<tr>
<td>Outpatient Psychotherapy</td>
<td>Covered sessions:</td>
<td>• Not required for first eight self-referred outpatient visits per FY</td>
<td>• A provider cannot bill for more than two sessions per calendar week (Sunday–Saturday)</td>
</tr>
<tr>
<td></td>
<td>• Individual psychotherapy</td>
<td>• Medical-necessity review and prior authorization required after first eight self-referred visits. 90791 and 90792 do not count against the first eight visits</td>
<td>without prior authorization</td>
</tr>
<tr>
<td></td>
<td>• Family or conjoint psychotherapy (session not to exceed 90 minutes but may extend up to 180 minutes for crisis intervention)</td>
<td></td>
<td>• When multiple sessions of the same type are conducted on the same day, only one session is reimbursed</td>
</tr>
<tr>
<td></td>
<td>• Group psychotherapy (session not to exceed 90 minutes) and not to be billed more than one unit per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Collateral visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Psychoanalysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological and Neuropsychological Testing</td>
<td>• Medical necessity must be established prior to testing</td>
<td>• Required, regardless of the setting</td>
<td>• Generally approved for up to six hours per FY and up to 10 hours per FY for neuropsychological testing</td>
</tr>
<tr>
<td></td>
<td>• Must be medically necessary and performed in conjunction with otherwise-covered psychotherapy</td>
<td></td>
<td>• Additional hours may be approved on a case-by-case basis</td>
</tr>
<tr>
<td>Medication Management (rendered by a TRICARE-certified provider)</td>
<td>• Covered when provided as an independent procedure</td>
<td>• Not required for up to two visits per month</td>
<td>• Up to two visits per month without prior authorization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Required for medication-management sessions exceeding two visits per month or when performed along with therapy</td>
<td></td>
</tr>
<tr>
<td>Electroconvulsive Therapy (ECT)</td>
<td>• Covered when medically necessary and in an inpatient setting. No prior authorization is required.</td>
<td>• Prior authorization is required for all ECT components when delivered in an outpatient setting.</td>
<td>• None</td>
</tr>
</tbody>
</table>
Inpatient Services

Inpatient Psychotherapy

Inpatient psychotherapy is limited to five sessions of any kind of psychotherapy per calendar week (Sunday–Saturday), unless medical review of the overall treatment plan for medical necessity and appropriateness is conducted.

Note: Facilities with all-inclusive contracts that include psychotherapy will not receive separate payment for inpatient psychotherapy.

All facilities, whether hospital-based or freestanding, must adhere to the balance billing, release of medical records, and waiver of non-covered services provisions outlined in the Important Provider Information section of this Handbook.

Acute Inpatient Care

The purpose of acute inpatient care is to stabilize a life-threatening or severely disabling behavioral health condition. TRICARE defines a psychiatric emergency admission as an admission when, based on a psychiatric evaluation performed by a physician (or other qualified behavioral health care provider with hospital admission authority), the beneficiary is at immediate risk of serious harm to self or others as a result of a behavioral health disorder and requires immediate continuous skilled observation at the acute level of care. In a life-threatening situation, the provider should direct the beneficiary to the closest appropriate health care facility. If an MTF is geographically available, referral to the MTF emergency room is appropriate. The beneficiary’s age at the time of admission determines the actual number of benefit days that can be authorized for acute inpatient care per FY. The limits are as follows:

- Up to 30 days for beneficiaries age 19 and older
- Up to 45 days for beneficiaries age 18 and younger

An inpatient admission for substance use detoxification and rehabilitation counts toward the 30- or 45-day limit per FY for inpatient behavioral health care services, regardless of whether the beneficiary is admitted to a general hospital or substance use disorder rehabilitation facility (SUDRF).

Prior authorization is required for all nonemergency admissions. Admissions resulting from a psychiatric emergency should be reported to UnitedHealthcare within 24 hours of the admission or the next business day after the admission, but must be reported within 72 hours of the admission. UnitedHealthcare will conduct a concurrent review for continuation of inpatient behavioral health care services and authorize additional days, as medically necessary. Admissions may be reported by faxing a completed Inpatient Emergency Admission—Mental Health form to UnitedHealthcare to:

Routine requests – 877-581-1590
Urgent requests – 877-579-8589

Waivers to the maximum benefit day limitation may be granted if the continued care meets certain requirements. Waiver requests must be submitted before the benefit is exhausted and can be granted only by the UnitedHealthcare behavioral health medical director. This is true of both inpatient care and partial hospitalization.

Post-hospital follow-up

As part of our Quality Management and Quality Improvement Programs, and to ensure that all beneficiaries have access to appropriate treatment following discharge from an inpatient level of care, we require network providers to adhere to industry best practice related to specific access standards including the following:

- An outpatient appointment must be scheduled by the facility and offered by the outpatient provider within seven days of an acute inpatient discharge.
- If you are unable to meet this standard, it is required that you notify your Network Manager that you are not available to accept referrals.
- The inpatient provider or designee will provide a written or verbal summary of the beneficiary’s needs to the receiving outpatient provider prior to discharge in order to coordinate continuity of care.
**Treatment, Recovery & Resiliency and Discharge Planning**

The treatment plan stems from the beneficiary’s presenting condition, and is used to document realistic and measurable treatment goals as well as the evidence-based treatments that will be used to achieve the goals of treatment. Effective treatment planning should also take into account significant variables such as:

- Age and level of development
- The beneficiary’s history of treatment
- Whether the proposed services are covered in the beneficiary’s benefit plan and are available in the community
- Whether community resources such as support groups, consumer-run services, and preventive health programs can augment treatment

Providers must also take into account the beneficiary’s preferences as might be directly expressed or documented in an advance directive or crisis plan, or whether some beneficiary’s treatment is part of a broader recovery and resiliency effort. Consequently the recovery and resiliency goals which may be documented in a recovery plan should also be considered.

A change in the beneficiary’s condition should prompt a reassessment of the treatment plan and selection of level of care. When the beneficiary’s condition has improved, the reassessment should determine whether a less restrictive level of care may be adequate to treat the condition, or whether he or she no longer requires treatment. When a beneficiary’s condition has not improved or it has worsened, the reassessment should determine whether the diagnosis is accurate, the treatment plan should be modified, or the condition should be treated in another level of care.

Effective discharge planning enables the beneficiary’s safe and timely transition from one level of care to another, and documents the services he or she will receive after discharge. Discharge planning begins at the onset of treatment when the provider anticipates the discharge date and forms an initial impression of the beneficiary’s post-discharge needs. The initial discharge plan may evolve in response to changes in the beneficiary’s condition and his or her preferences. The final discharge plan should document the following:

- anticipated discharge date, the proposed post-discharge services
- the plan to coordinate discharge with the provider at the next level of care when indicated
- and the plan to reduce the risk of relapse such as by confirming that the beneficiary understands and agrees with the discharge plan.

The risk of relapse should be mitigated by arranging a timely first post-discharge appointment. The discharge summary, including the scheduled follow up appointment date and provider’s name, must be provided to both UnitedHealthcare and to the beneficiary’s assigned PCM. The PCM may be either a provider at the MTF or a provider in the civilian network.

As the beneficiary transitions from one level of care to another, UnitedHealthcare expects that the first appointment at the next level of care will be scheduled commensurate with the beneficiary’s needs. The first post-discharge appointment following inpatient care should occur no later than seven days from the date of discharge in accordance with the HEDIS® standard for follow-up treatment after discharge from inpatient care. Compliance with this standard is assessed on an annual basis.

Our Utilization Managers monitor discharge planning, and are available to assist with identifying and facilitating access to available treatment services and community resources.

UnitedHealthcare expects that the provider will collaborate with the beneficiary during treatment, recovery and discharge planning whenever possible.

**Psychiatric Partial Hospitalization Programs (PHP)**

Partial hospitalization is treatment where the beneficiary spends at least three hours a day, not to exceed six hours a day, up to five days a week at the facility (the treatment may also occur during weekends or evenings), but then goes home at night. PHP may be offered as full day (five to six hours) or half day (three to four hours) for between two and five days a week as clinically indicated for the individual beneficiary. A psychiatric PHP provides an appropriate setting for crisis stabilization or treatment of partially stabilized mental health disorders. It also serves as a transition from an inpatient program when medically necessary.

A TRICARE-authorized psychiatric PHP can be either a distinct part of an otherwise TRICARE-authorized institutional provider or a freestanding program:
• Hospital-based PHP: A hospital-based PHP is not required to have separate TRICARE certification from the TRICARE Quality Monitoring Contractor (TQMC), the Keystone Peer Review Organization (KePRO). A PHP that is part of a TRICARE-authorized hospital is also considered TRICARE-authorized.

• Freestanding PHP: All freestanding PHP must be TRICARE-certified by the TQMC, KePRO, to provide partial hospitalization programs to TRICARE-eligible beneficiaries. If so certified, this freestanding PHP may then enter into a participation agreement with TRICARE to become TRICARE certified. Providers may contact KePRO by any of the following means:

<table>
<thead>
<tr>
<th>Mail</th>
<th>KePRO ATTN: TRICARE Operations 777 East Park Drive Harrisburg, PA 17111</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>877-841-6413</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:tricare@kepro.com">tricare@kepro.com</a></td>
</tr>
</tbody>
</table>

Note: UnitedHealthcare is not able to waive this TRICARE policy requirement for freestanding PHP certification.

A psychiatric PHP facility must be capable of providing an interdisciplinary program of medically therapeutic services at least three hours per day, not to exceed six hours a day, up to five days per week as clinically indicated. This can include day, evening, or weekend treatment.

Psychiatric PHP coverage details:

• Referrals and prior authorizations are required for all psychiatric PHP admissions. A Preauthorization for Partial Hospitalization form must be completed and faxed to 877-581-1590 for routine requests, or 877-579-8589 for urgent requests. At this time, an online profile for PHP is not available.

• Psychiatric PHP care is limited to a maximum of 60 treatment days (whether a full-day or half-day program) per FY or for any single admission. The limit may be waived if the treatment is determined to be medically necessary.

• The 60 psychiatric PHP treatment days are not offset by, nor counted toward, the inpatient limit of 30 days for beneficiaries age 19 and older or 45 days for beneficiaries age 18 and younger.

• Concurrent medical necessity reviews are conducted during the course of the stay.

• Waivers to the maximum benefit day limitation may be granted if the continued care meets certain requirements. Waiver requests must be submitted before the benefit is exhausted and can be granted only by the UnitedHealthcare behavioral health medical director.

Filing Claims for Facilities Subject to the Outpatient Prospective Payment System

The TRICARE outpatient prospective payment system (OPPS) is used to pay claims filed for hospital outpatient services, including hospital-based PHPs subject to TRICARE’s prior authorization requirements. TRICARE OPPS is mandatory for both network and non-network providers.

TRICARE has adopted Medicare’s reimbursement methodology for hospital-based PHPs. There are two separate ambulatory payment classification (APC) payment rates under this reimbursement methodology:

• APC 0175: For days with three services
• APC 0176: For days with four or more services

TRICARE allows physicians, clinical psychologists, clinical nurse specialists, nurse practitioners and physician assistants to bill separately for their professional services delivered in a PHP. The only professional services that are included in the PHP payment are those furnished by clinical social workers, occupational therapists, and alcohol and addiction counselors.

To bill for partial hospitalization services under the hospital-based OPPS, hospitals are to use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and revenue codes and report psychiatric partial hospitalization services under bill type 013X, along with condition code 41 on the UB-04 claim form. The revenue code and HCPCS code must be billed separately for each date of service.
Filing Claims for Facilities Not Subject to the Outpatient Prospective Payment System

Facilities not subject to OPPS, including children’s hospitals, VA and freestanding PHPs (psychiatric and SUDRFs), will continue to be reimbursed under the PHP payment subject to TRICARE’s prior authorization requirements.

Residential Treatment Centers (RTCs)

RTCs provide treatment for children and adolescents (some centers may provide treatment up to age 21) who require behavioral health care due to a serious behavioral health disorder. Children who only have disciplinary problems or primary substance use disorders or a primary diagnosis of Autism Spectrum Disorder, do not qualify for treatment in an RTC setting.

All RTCs must be TRICARE-certified by the TQMC, KePRO, to provide residential treatment to TRICARE-eligible beneficiaries. Providers may contact KePRO by any of the following means:

| Mail          | KePRO  
|---------------|--------
|               | ATTN: TRICARE Operations 
|               | 777 East Park Drive Harrisburg, PA 17111 |
| Phone         | 877-841-6413 |
| Email         | tricare@kepro.com |

Note: UnitedHealthcare is not able to waive this TRICARE policy requirement for KePRO certification of RTCs. A psychiatrist or clinical psychologist must recommend the child be admitted to the RTC, and a psychiatrist or clinical psychologist must direct the development of a treatment plan. Documentation must be submitted to support each request, and the behavioral health disorder must meet clinical review criteria before admission can be authorized.

Additional RTC details:

- RTC care is covered to a maximum of 150 days per FY or for a single admission, when medically or psychologically necessary. These limits are subject to waiver in certain cases.

- Prior authorization is required. The Residential Treatment Center (RTC) Application must be completed and faxed to 877-581-1590 for routine requests, or 877-579-8589 for urgent requests. At this time, an online profile for RTC care is not available. Facilities must be TRICARE authorized. Admission primarily for substance use rehabilitation is not authorized.

- Concurrent medical necessity reviews are conducted during the course of the RTC stay.

TRICARE reimbursement for RTC care is an all-inclusive rate. The only three charges considered outside the all-inclusive RTC rate are:

- Geographically distant family therapy: (GDFT) The family therapist may bill and be reimbursed separately from the RTC if the therapy is provided to one or both of the child’s parents residing a minimum of 250 miles from the RTC. Prior authorization is required for all geographically distant family therapy. Family engagement in GDFT is required for an RTC service to be approved.

- RTC educational services: Educational services will be covered only in cases when appropriate education is not available from, or not payable by, local, state, or federal governments. TRICARE is always the last payer. For network providers, this coverage limitation applies only if educational services are not part of the contracted rate.

- Non-behavioral health care services: Services provided to the beneficiary not related to behavioral health care, such as medical treatments for asthma or diabetes, may be reimbursed separately from the RTC.
## Inpatient Mental Health Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
<th>Prior Authorization Notification</th>
<th>Frequency Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Inpatient Care</strong></td>
<td>• Stabilizes a life-threatening or severely disabling mental health condition&lt;br&gt;• Psychiatric emergency admissions are required when, based on psychiatric evaluation, a beneficiary is at immediate risk of serious harm to self or others and requires immediate, continuous skilled observation</td>
<td>• Prior authorization is required for all nonemergency admissions&lt;br&gt;• Notification of Psychiatric emergency admissions must be reported within 24 hours of the admission or the next business day, but no later than 72 hours following the admission&lt;br&gt;• The facility will arrange for an outpatient follow up appointment to occur no later than seven days post discharge and will communicate relevant clinical information to the receiving outpatient provider and to the assigned beneficiary PCM</td>
<td>• Up to 30 days for beneficiaries age 19 and older&lt;br&gt;• Up to 45 days for beneficiaries age 18 and younger&lt;br&gt;• Admission for substance-use detoxification and rehabilitation count toward the 30- or 45-day limit per FY&lt;br&gt;• Limits may be waived if the treatment is determined to be medically necessary</td>
</tr>
<tr>
<td><strong>Residential Treatment Center (RTC)</strong></td>
<td>• Covered for patients (up to age 21) requiring behavioral health care due to a serious behavioral health disorder&lt;br&gt;• Children who only have discipline problems, primary substance use disorder or primary autism disorder do not qualify for residential treatment</td>
<td>• Prior authorization is required prior to admission&lt;br&gt;• Family participation in GDFT is required</td>
<td>• Up to 150 days per FY or for a single admission, when medically necessary&lt;br&gt;• Limits may be waived if the treatment is determined to be medically necessary</td>
</tr>
<tr>
<td><strong>Psychiatric Partial Hospitalization Program (Hospital setting)</strong></td>
<td>• Crisis stabilization or treatment of partially stabilized behavioral health disorders&lt;br&gt;• May serve as a transition from an inpatient program when medically necessary, or as an alternative level of care when inpatient may not be required</td>
<td>• Prior authorization is required prior to admission&lt;br&gt;• May be half day (three hours) or full day (four or more hours) for two to five days a week as clinically indicated</td>
<td>• Up to 60 days (full-or half-day program) per FY or for any single admission&lt;br&gt;• Limits may be waived if the treatment is determined to be medically necessary</td>
</tr>
<tr>
<td><strong>Psychiatric Partial Hospitalization Program (Freestanding setting)</strong></td>
<td>• Crisis stabilization or treatment of partially stabilized behavioral health disorders&lt;br&gt;• May serve as a transition from an inpatient program when medically necessary, or as an alternative level of care when inpatient may not be required</td>
<td>• Prior authorization is required prior to admission&lt;br&gt;• May be half day (three to five hours) or full day (six or more hours) for two to five days a week as clinically indicated</td>
<td>• Up to 60 days (full-or half-day program) per FY or for any single admission&lt;br&gt;• Limits may be waived if the treatment is determined to be medically necessary</td>
</tr>
</tbody>
</table>

## Alcoholism and Other Substance Use Disorders

Substance use disorder treatment is only covered when provided by a TRICARE-authorized hospital or an organized substance use disorder treatment program in a TRICARE-authorized freestanding or hospital-based SUDRF. Treatment may include outpatient and/or inpatient services.

## Outpatient Care for Alcoholism or Other Substance Use Disorders

TRICARE provides coverage for up to 60 facility-based outpatient therapy visits (individual or group) over the course of a benefit period, beginning the first day of the rehabilitation phase of treatment. Family therapy is covered for up to 15 visits per benefit period, beginning the first day of therapy.

Non-facility-based outpatient services are not a covered benefit for a beneficiary with a primary diagnosis of substance use disorder/dependence. All outpatient substance use disorder services must be provided in a TRICARE-authorized freestanding or hospital-based SUDRF. However, it may be covered if a co-occurring mental health condition is a part of the presenting problem and a focus of treatment.
Waivers to the maximum benefit day limitation may be granted if the continued care meets certain requirements. This also applies to both inpatient care and partial hospitalization. Exceptions will be considered based on medical necessity review, or by meeting the standards for waivers. For more information refer to the TRICARE Policy Manual, Chapter 7, Section 3.7.

**Inpatient Detoxification**

Detoxification services are covered when medically necessary for the active medical treatment of the acute phases of substance use withdrawal (detoxification), for stabilization, and for the treatment of medical complications of substance use disorders. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. Admissions may be reported by faxing a completed Inpatient Emergency Admission -Detox form to UnitedHealthcare at 877-579-8589.

The following details apply to detoxification:

- Covered for up to seven days per episode in a TRICARE-authorized SUDRF, if medically necessary.
- Counts toward the maximum of 30-or 45-days (depending on the patient's age) of inpatient behavioral health care allowed per FY.
- Does not count toward the 21 days of rehabilitation addressed in the following section, Substance Use Rehabilitation.

**Substance Use Rehabilitation**

Rehabilitative care may occur in an inpatient or partial hospitalization setting. In a partial hospital setting, care must be provided at TRICARE-authorized SUDRFs certified through KePRO. All freestanding SUDRFs must be TRICARE-certified by the TQMC, KePRO, to provide partial hospital programs to TRICARE-eligible beneficiaries. If so certified, this freestanding SUDRF may then enter into a participation agreement with TRICARE to become TRICARE certified.

Providers may contact KePRO by any of the following means:

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**Note:** UnitedHealthcare may not waive the TRICARE policy requirement for KePRO certification. The following details apply to substance use rehabilitation:

- Prior authorization is required for rehabilitation stays. A Preauthorization for Inpatient Substance Abuse Rehabilitation form or Preauthorization for Partial Hospitalization form must be completed and faxed to 877-581-1590 for routine requests, or 877-579-8589 for urgent requests. At this time, an online profile for substance use rehabilitation is not available.
- Care is covered for up to 21 days of rehabilitation per benefit period in a TRICARE-authorized SUDRF (includes inpatient and partial hospitalization days or a combination of both).
- Coverage is subject to the following limits:
  - One treatment episode in a one-year benefit period (begins with the first day of treatment and ends 365 days later)
  - Three treatment episodes during a person’s lifetime
  - Days for rehabilitation count toward the 30-or 45-day limit per FY (depending on the patient’s age) for acute inpatient psychiatric care
- TRICARE shares the cost of SUDRF partial hospitalization rehabilitation treatment for up to 21 days at a predetermined, all-inclusive rate.
- PHP SUDRFs must submit charges for substance use disorder treatment on a UB-04 form.
For information on PHP claims, see the Claims Processing and Billing Information section of this Handbook.

### Substance Use Disorder Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
<th>Prior Authorization</th>
<th>Frequency Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Detoxification</td>
<td>Covered for complications of alcohol and drug abuse or dependency and detoxification only when the patient's condition is such that the personnel and facilities of a hospital are required</td>
<td>Required for all nonemergency admissions Notification of emergency admissions must be reported within 24 hours of the admission or the next business day</td>
<td>Up to seven days per episode in a TRICARE authorized hospital or TRICARE-authorized freestanding substance use disorder rehabilitation facility (SUDRF) Days count toward 30-or 45-day inpatient behavioral health care limit</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>Must be a TRICARE-authorized hospital or SUDRF (freestanding or hospital-based)</td>
<td>Required</td>
<td>Up to 21 days of rehabilitation per benefit period (combined partial and/or inpatient) Up to three treatment episodes per lifetime Days count toward 30-or 45-day limit for inpatient psychiatric care</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>Must be a TRICARE-authorized freestanding or hospital-based SUDRF</td>
<td>Required</td>
<td>Up to 60 facility-based visits (individual or group) per benefit period Up to 15 family therapy visits per benefit period</td>
</tr>
<tr>
<td>Partial Hospitalization Program</td>
<td>Must be a TRICARE-authorized hospital or SUDRF (freestanding or hospital-based)</td>
<td>Required</td>
<td>PHP rehabilitation days count toward the 21-day rehabilitation limit (may be combination of inpatient rehabilitation days and PHP)</td>
</tr>
</tbody>
</table>

### Court-Ordered Care

Court-ordered care is defined by TRICARE as medical services, including inpatient admissions, which a party in a legal proceeding is ordered or directed to obtain by a court of law. The fact that behavioral health care services are ordered by a court for a TRICARE-eligible beneficiary does not determine the benefits available under TRICARE. TRICARE benefits are paid only if the services are medically or psychologically necessary to diagnose and/or treat a covered condition and are for covered TRICARE services provided by a TRICARE-authorized provider. The services must be at the appropriate level of care to treat the condition, and the beneficiary (or family) must have a legal obligation to pay for the services.

### Non-Covered Behavioral Health Care Services

The following are examples of behavioral health care services not covered under TRICARE. **This list is not all-inclusive.**

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

**Sexual Disorders**

Sexual dysfunction is characterized by disturbances in sexual desire and by the psychophysiological changes that characterize the sexual response cycle, causing marked distress and interpersonal difficulties. Any therapy, service, or supply provided in connection with sexual dysfunction or inadequacies is excluded from TRICARE coverage. Exclusions include therapy, services, or supplies for these disorders/dysfunctions:

• Gender identity disorders—characterized by strong and persistent cross-gender identification accompanied by persistent discomfort with one’s assigned gender
• Orgasmic disorders (e.g., female orgasmic disorder, male orgasmic disorder, premature ejaculation)
• Paraphilias (e.g., exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism, and paraphilia not otherwise specified)
• Sexual arousal disorders (e.g., female sexual arousal disorder, male erectile disorder)
• Sexual desire disorders (e.g., hypoactive sexual desire disorder, sexual aversion disorder)
• Sexual dysfunction due to a general medical condition
• Sexual dysfunctions not otherwise specified, including those with organic or psychogenic origins
• Sexual pain disorders (e.g., dyspareunia, vaginismus)
• Substance-induced sexual dysfunction

**Behavioral Health Care Management**

For information about claims processing and billing, refer to the [Claims Processing and Billing Information](#) section of this Handbook.

For information about case management, refer to the [Health Care Management and Administration](#) section of this Handbook.

For information about provider credentialing and contracting, refer to the [Important Provider Information](#) section of this Handbook.

UnitedHealthcare Military & Veterans created a beneficiary-centered, General Care Management model of care that serves beneficiaries with complex medical or behavioral conditions. This model provides for the integrated medical and behavioral interventions for beneficiaries who would most benefit from telephonic or on the ground face-to-face case management. The model focuses on improving the beneficiary’s quality of life by honoring and supporting the individual’s unique traditions, attitudes, beliefs and addressing their physical, behavioral, psycho-social, environmental and spiritual domains of care.

Best practice guidelines demonstrate that when beneficiaries are provided with comprehensive care management which focuses on beneficiary and family engagement, education of condition trajectories, treatment options, and symptom management; coordination of services and advocacy, the quality of life for beneficiaries and families increase. General Care Management will be delivered telephonically as well as in the community where available. Nine sites have been selected to provide community or field based case management. These sites where selected on the density of population served.
The General Case Management model is a comprehensive, evidenced-based approach facilitating appropriate, quality care. Interventions are integrated within a complex case management, and community health services delivery model that improves outcomes and assures appropriate care through:

- Proactive beneficiary identification via direct referrals and predictive modeling tools
- Telephonic and or face-to-face engagement
- Ability to provide consultative (one time), episodic or longitudinal care
- Assessment of current and future needs
- Assistance with clarity of goals of care, and alignment with medical and behavioral plan of care
- Shared development and participation in creating a beneficiary centered plan of care
- Coordination of quality care at all levels of the healthcare system
- Advocating for beneficiary-centered care that encourages mutual participation relationships, informed choice and beneficiary autonomy.

General Care Management interventions are designed to:

- Minimize physical, psychological and spiritual distress and positively affect the lives of beneficiaries, their family and significant others
- Increase beneficiary understanding of the expected course of conditions, risk and benefits or treatment, value of preventative and proactive care and increase adherence to medical and behavioral plans of care
- Support the alignment of the course of treatment and plan of care with beneficiary values and goals
- Empower the beneficiary and family to become more proactive participants in the medical care they receive
- Improve quality of life for beneficiaries and their family
- Reduce medical spend through proactive education and active interventions to avoid duplicative or unnecessary care

- Community Case Management Program is a community based integrated complex care management model which combines the professional disciplines of med-surg practitioner and behavioral health practitioners to deliver care in the community in the beneficiary’s home. It is a non-emergent, non-direct care management model that incorporates principles of behavioral health, community health, preventative and public health and palliative care. The program focuses on individuals with complex conditions. The program provides specially trained nurses and behavioral health professionals to deliver face-to-face care.

  › Available in these nine areas
    - Phoenix, AZ
    - Tucson, AZ
    - San Diego, CA
    - San Francisco, CA
    - Colorado Springs, CO
    - Honolulu, HI
    - Las Vegas, NV
    - El Paso, TX
    - Tacoma, WA

UnitedHealthcare Military & Veterans is committed to health and wellness and dedicated to ensuring access to efficient, quality health care to TRICARE beneficiaries. We provide medical management services that ensure adequate resources are provided at the right time, by the right provider and in the right setting and environment. Our goal is to support the Quadruple Aim for Force Readiness and to support those who are serving, or have served, and their families. Behavioral health is a specialized component of our case management programs thoroughly integrated administratively and programmatically within Medical Management.
Behavioral Health (BH) General Case Management (GCM) and Community Case Management (CCM) provides assessment, stratification and individualized interventions to support beneficiaries dealing with mental health and substance use disorders. It also is designed to provide active support to all medical/surgical (M/S) case management programs (General, Specialty and Complex) when co-morbid medical and behavioral conditions present.

Providing BH GCM for TRICARE beneficiaries requires a special understanding of the needs of the population and the types of services needed. The unique ongoing stressors of current and prolonged deployments and family separation are taking a toll on our active duty service members (ADSM) and active duty family members (ADFM). It is estimated that 11.2 percent of deployed ADSM’s have post-traumatic stress disorder (PTSD) or major depression without traumatic brain injury (TBI) and 7.3 percent have PTSD or MDD with TBI. Combined, this is 18.5 percent or nearly twice the rate seen in pre-deployment assessments (5 percent for PTSD and 5 percent for Major Depressive Disorder (MDD). Studies suggest that over 300,000 individuals currently suffer from PTSD or MDD. Rates of suicide in ADSM now pass the rate of suicide in the general population.

The BH Case Management Program provides CM services to all eligible TRICARE beneficiaries as needed. This program leverages traditional CM services with a highly structured, goal oriented blend of self-directed and telephonic delivery of support for beneficiaries with moderate to high risk impairment.

Recognizing the unique needs of all TRICARE beneficiaries, our BH CM teams will guide beneficiaries to military treatment facilities (MTF) and network providers and identify additional programs and services based on their care level, medical necessity, symptoms, qualifying events and overall medical, psychological and functional health status. The foundation of BH CM efforts lies in conducting a comprehensive initial assessment that evaluates biological, behavioral, familial, social and economic variables and assessing barriers to care. Problems, goals and interventions are established that align with the beneficiary’s preferences and conditions. The individualized plan of care will then drive toward reducing barriers to care and improving outcomes for individuals. The level of intervention is determined by the assessment(s) performed, engagement of the beneficiary in a care plan and titrated to the beneficiaries needs and preferences. When appropriate, we will work collaboratively with PCMs, medical and behavioral practitioners and other health care providers to promote a seamless delivery of health care services.

Integration of service is a core foundation of our approach to service support. Using established tools as part of standard operating procedures, BH case managers assess for medical conditions and are effectively trained in managing behavioral conditions with a mild to moderate medical co-morbidity. Clinical rounds involving consultation with a behavioral health medical director and a medical/surgical medical director reinforce this knowledge and competency. Consultation and collaboration with M/S peer case managers is encouraged and measured. Similarly, BH case managers provide equal support to peers to assist in managing medical/surgical conditions that have a mild to moderate behavioral co-morbidity. Our case management programs also integrate the medical benefits reimbursement structure, beneficiary and practitioner education, and quality controls to monitor cost and quality of service to its beneficiaries. A cornerstone of success in medical management programs is our ability to effectively collaborate and optimize health outcomes for individuals with co-morbid medical and behavioral conditions, improve overall quality of life and potentially reduce costs for the DoD.

Behavioral Health Case Management will work closely with Utilization Management, Referral Management, M/S CM (Community, General, Specialty and Complex CM), customer service, claims and network management to facilitate optimal outcomes for the TRICARE population.

**Behavioral Health Care Medical Record Documentation**

The following information must be included in each beneficiary’s record. The credentials or provider type for each provider represented in the record should appear at least once.

- Beneficiary identification (name and identification number) on each page
- Allergies
- Immunization status
- Date of visit
- Chief complaint/problem
- History of problem
- Physical assessment
• Diagnosis/impression
• Treatment plan goals
• Appropriate discharge planning
• Legible provider name(s)/signature(s)
• Consent to treatment forms
• Pertinent legal information

Initial Evaluation
The medical record of the beneficiary’s initial evaluation must contain a description and history of the presenting problem(s), including precipitating factors, as well as the items discussed below. A mental status examination is part of every treatment record and should include beneficiary information on the following:

• Orientation to person, place, time, and situation
• Affect and mood
• Speech and thought content
• Judgment, insight, and impulse control
• Attention, concentration, and memory
• A detailed medical and behavioral health history including
  › Previous practitioners and treatment dates
  › Therapeutic interventions and responses
  › Sources of clinical data
  › Relevant family information
  › Results of laboratory and psychological tests
  › Consultation reports
• Suicidal ideation
• Homicidal ideation
• Other relevant factors

An appropriately detailed psychosocial history includes items about family, education, occupation, relevant legal information, and relationship/social histories. For children and adolescents, the detailed psychosocial history must include:

• Prenatal and perinatal events
• A development history, including physical, psychological, social, intellectual, and academic spheres
• Information about the presence or absence of medication use and other substance use (If prescribed by the practitioner, notations must clearly indicate all dosages, dates of initial prescriptions, and refills.)
• A list of relevant medical conditions, prominently identified and revised
• List any known medications that the beneficiary is taking
• Information about the presence or absence of allergies and sensitivities to pharmaceuticals and other substances
• A completed substance use disorder evaluation for beneficiaries age 12 and older that includes past and present use of alcohol, tobacco products, caffeine, and prescribed and over-the-counter drugs
• A risk assessment and information about special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential (must include updated management plans)
• Documentation of a DSM diagnosis consistent with the presenting problem(s), history, mental status examination, and other assessment data
• Continue to list medical conditions, psychosocial and environmental factors, and functional impairment(s) that support understanding of mental health condition
• Documentation that a follow-up appointment has been scheduled

Treatment Plan Documentation
The treatment plan documentation should make clear the relationship between the diagnosis/case formulation and the treatment plan. The treatment plan must be individualized to the beneficiary, and must include:

• Objective, measurable goals
• Estimated time frames for goal attainment or problem resolution
• Evidence of the beneficiary’s understanding of the treatment plan
• Ongoing review of the beneficiary’s progress and the effectiveness of the treatment plan

Progress Noted in Treatment Records
Progress notes must be individualized, and describe the beneficiary’s strengths and limitations in achieving treatment plan goals, including environmental factors that support change or may serve as obstacles to progress. These progress notes must include:

• Documentation that all concurrent, relevant caregivers (e.g., consultants, primary physicians, ancillary practitioners, health care institutions) are contacted or involved in treatment and show evidence of continuity and coordination of care. (Note: Also indicate if none of the above caregivers is involved.)
• Documentation that the beneficiary is referred for, and receiving medication evaluation for, psychotropic medication, if applicable
• Dates of subsequent appointments at each contact
• A discharge plan, when appropriate, that includes:
  › Final DSM-5 diagnosis
  › Continue to list medical conditions, psychosocial and environmental factors and functional impairments(s) that support understanding of mental health condition
  › Discharge summary
  › Discharge instructions given to beneficiary or family
  › Documentation of the beneficiary’s achievement of goals or necessary referrals to assist in the final attainment of goals
  › Documentation of the beneficiary’s perception of goals being achieved/not achieved.

Notes that are clearly “template”, (e.g. repetition is identified for all beneficiaries), are not acceptable and do not represent individualized care

Medication Management Records
To adhere to TRICARE procedures and requirements, medication management records must include:

• A completed medication flow sheet or progress notes documenting current psychotropic medication(s), dosage(s), and date(s) of dosage changes
• Documentation of beneficiary education regarding possible medication side effects
• Documentation that the reason for medication was explained to the beneficiary
• Documentation of education for women of childbearing age to avoid becoming pregnant while taking psychotropic medication and to notify psychiatrist immediately upon becoming pregnant
• Documentation of beneficiary understanding of medication education
• Record reflecting that Drug Enforcement Agency-scheduled drugs are avoided in the treatment of beneficiaries with a history of substance use disorder/dependency

**Outside Resources Documentation**
If outside resources are used for care, the following documentation must be included:

• Documentation of the use of resources outside therapeutic encounters, including appropriate preventive services, such as relapse-prevention strategies, lifestyle changes, stress management, wellness programs, and referrals to community resources
• Prompt referral of beneficiaries who become homicidal, suicidal, or unable to conduct activities of daily living to the appropriate level of care

**Inpatient Medical Records**
All inpatient—including RTC and PHP—behavioral health records must contain the following:

• Psychiatric admission evaluation report within 24 hours of admission
• History and physical examination within 24 hours of admission (the complete report must be documented within 72 hours of acute and RTC programs and within 3 working days for PHPs)
• Individual and family therapy notes within 24 hours of procedure for acute care, detoxification, and RTC programs, and within 48 hours for PHPs
• Preliminary treatment plan within 24 hours of admission
• Master treatment plan within five calendar days of admission for acute care, 10 days for RTC care, five calendar days for full-day PHPs, and seven calendar days for half-day PHP;
• Family assessment report within 72 hours of admission for acute care and within seven calendar days for RTCs and PHPs
• Nursing assessment report within 24 hours of admission
• Nursing notes at the end of each shift for acute and detoxification programs, after every 10 visits for PHPs, and at least once a week for RTCs
• Physician notes daily for intensive treatment, detoxification, and rapid stabilization programs, twice per week for acute programs, and once per week for RTCs and PHPs
• Group therapy notes once per week
• Ancillary service notes once per week

Additionally, any consultations, studies, and treatments must be documented with indication of results. A statement of informed consent must also be provided for any invasive treatments.

**Individual Provider (Office) Medical Records**
The individual provider (office) medical record must include the beneficiary’s:

• Address
• Address and telephone number of at least one designated emergency contact
• Employer and/or school name(s)
• Guardianship information, if applicable
• Home and alternative telephone numbers
• Marital/legal status
Informed consent for evaluation, treatment, and communications signed by the beneficiary or the legal guardian should also be a part of the medical record. Each clinical entry must clearly indicate date, type of contact, practitioner's signature, and practitioner's credentials. Additionally, each medical record must contain documentation showing communication with the beneficiary's primary physician.

**Behavioral Health Care Coverage Details**

Figures 7.4 through 7.8 on the following pages offer benefit summary details for covered behavioral health care services based on plan type.

### Behavioral Health Care Coverage Details: Coverage Details

#### Behavioral Health Evaluation and Therapy

- Benefits provide up to two routine therapy sessions per week; more frequent visits require additional authorization.
- Each beneficiary (except ADSMs) may self-refer for the first eight routine outpatient mental health therapy sessions per FY (Oct. 1–Sept. 30) without medical necessity review or prior authorization; sessions beyond the initial self-referred eight require medical necessity review and prior authorization. ADSMs must follow the protocol within their MTFs for obtaining behavioral health care within the MTFs. For care outside of the MTFs, ADSMs must have referrals and prior authorizations from their PCMs or, if enrolled in TRICARE Prime Remote, from their Service Points of Contact.

**Notes:**
- The initial eight self-referred routine outpatient mental health care visits for covered benefits do not require a PCM referral; non-ADSM beneficiaries may self-refer. Diagnostic Interview (90791 or 90792) does not count against the initial eight visits. Only one unit of a diagnostic interview, per provider may be allowed in a FY, or two per beneficiary if provided by separate providers (ADSMs must follow procedures as noted above.)
- TRICARE Prime beneficiaries must self-refer to network providers.
- Typical individual therapy sessions are 45-50 minutes in duration. Individual sessions of greater duration may require authorization.
- Supervised mental health counselors and pastoral counselors require physician referrals and ongoing supervision with the referring physician. A copy of the referral should be kept in the patient's chart and the referring physician's name should be on the claim form in box 17.
- Providers are allowed one initial evaluation per beneficiary per FY without authorization. It does not count as a therapy session within the initial eight self-referred outpatient visits available to non-ADSMs. Additional evaluations in the same FY require prior authorization, regardless of whether the first eight visits without a referral have been met.

#### Substance Use Disorders

- Benefit period begins with the first day of covered treatment and ends 365 days later.
- Benefits provide up to 60 individual or group outpatient therapy sessions and up to 15 family therapy sessions per benefit period.
- Services always require prior authorization.
- Services must be rendered by TRICARE-authorized institutional providers. These providers must be either a TRICARE-authorized hospital or an organized substance use disorder treatment program in a TRICARE-authorized freestanding or hospital-based SUDRF.

#### Other Outpatient Services

- Psychological testing is generally approved up to six hours per year and requires a medical-necessity review and prior authorization.
- Medication management checks do not require medical necessity review or authorization for up to two visits per month and do not count against the initial eight self-referred therapy sessions.
- Electroconvulsive therapy (ECT) always requires medical necessity review and prior authorization.
### Behavioral Health Care Inpatient Services: Coverage Details

#### Behavioral Health Disorder
- Benefits provide up to 30 days per FY, (Oct. 1–Sept. 30) or per admission for acute inpatient care for beneficiaries age 19 and older.
- Benefits provide up to 45 days per FY or per admission for acute inpatient care for beneficiaries age 18 and younger.
- Benefits provide up to 150 days per FY or per admission for care in TRICARE-approved residential treatment centers for beneficiaries under age 21 (dependent upon facility age restrictions).
- All nonemergency admissions require prior authorization.

#### Substance Use Disorders: Acute Inpatient Care/Detoxification
- Covered for complications of alcohol and drug abuse or dependency and detoxification only when the patient’s condition is such that the personnel and facilities of a hospital are required.
- Covered for up to seven days per episode in a TRICARE-authorized facility.
- Days count toward the 30 or 45 day behavioral health care inpatient limit.
- All nonemergency admissions require prior authorization.
- Services must be rendered by TRICARE-authorized institutional providers. These providers must be either a TRICARE-authorized hospital or an organized substance use disorder treatment program in a TRICARE-authorized freestanding or SUDRF.

#### Substance Use Disorders: Rehabilitation
- Benefit period starts the first day of covered treatment and ends 365 days later.
- Benefits provide up to 21 days per benefit period (combined partial and/or inpatient).
- Up to 7 days of detoxification are allowed per episode in addition to the 21 rehabilitative days.
- Days count toward the 30 or 45 day behavioral health care inpatient limit.
- Benefits provide up to one treatment episode in a one year period and up to three treatment episodes during the beneficiary’s lifetime.
- All nonemergency admissions require prior authorization.
- Services must be rendered by TRICARE-authorized institutional providers. These providers must be either a TRICARE-authorized hospital or an organized substance use disorder treatment program in a TRICARE-authorized freestanding or SUDRF.

### Behavioral Health Care Psychiatric PHPs: Coverage Details

#### All Partial Hospitalization Program (PHP) Services
- All services require medical necessity review and prior authorization.
- A minimum of three hours of therapeutic services are allowed up to five days per week, and may include day, evening, night, and weekend programs.

#### Behavioral Health Disorder
- Benefits provide up to 60 treatment days per beneficiary, per FY.
- The 60 treatment days are not offset by or counted toward the 30 or 45 day inpatient limit.
- Care must be provided in a TRICARE-authorized psychiatric PHP.

### Non-Covered Behavioral Health Care Services

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

**Figure 7.8**

<table>
<thead>
<tr>
<th>TRICARE Prime (Includes TRICARE Prime Remote, TRICARE Prime Remote for Active Duty Family Members, and TRICARE Young Adult Prime)</th>
<th>TRICARE Standard and TRICARE Extra (Includes TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult Standard)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADSMs and ADFMs</strong></td>
<td><strong>Retirees, Their Families, and All Others</strong></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Behavioral Health</strong></td>
<td>$0 copayment per visit</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Behavioral Health</strong></td>
<td>$0 per day</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*In addition to the costs listed above, point-of-service (POS) charges may apply if TRICARE Prime beneficiaries seek nonemergency care from a TRICARE-authorized provider without a referral from the PCM. See the TRICARE Prime Point-of-Service Option (POS) section of this Handbook for more information.*

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### Health Care Management and Administration

#### Referrals and Authorizations

A referral is the process of sending a TRICARE Prime patient to another professional provider for a consultation or health care service when the requested service is outside the scope of practice for the referring provider. A referral is required for most services for TRICARE Prime beneficiaries if the service is provided by a civilian provider other than the PCM. ADSMs must always have referrals for all care outside of a MTF, except for emergencies. The MTF must be aware of all treatment received by the ADSM to ensure that he or she remains fit for duty. Referrals or prior authorizations are required for most services for TRICARE Prime, TPR, and TPRADFM beneficiaries, even if the service is not listed on the West Region Prior Authorization List. Referrals are not the same as prior authorizations.

A prior authorization is a request for services, a procedure, or admission to a hospital or facility that must be obtained before any service is given (or within 24 hours after an emergency admission unless otherwise specified in the provider’s contract). Authorizations must be obtained prior to services being delivered for those services on the Prior Authorization List, which can be found at UHCMilitaryWest.com > Providers > Referrals and Prior Authorizations.

When a TRICARE Prime beneficiary’s PCM is unable to provide a specialized medical service, the PCM must request a referral and prior authorization (as appropriate) from UnitedHealthcare. UnitedHealthcare approves a referral when a TRICARE Prime beneficiary needs specialized medical services from a professional or ancillary provider and the services are not available at the...
MTF. The MTF is always the primary source of care for TRICARE Prime beneficiaries. The MTF has right of first refusal (ROFR) to provide care for a Non-Active Duty (NAD) TRICARE Prime beneficiary. Refer to the ROFR section of this Handbook for more information regarding ROFR. In addition, the MTF reserves the right to approve or deny any care requested for an ADSM. Referral or authorization request for all services (medical, surgical) should be completed online. However, if your request must be faxed to UnitedHealthcare use the following numbers:

- Urgent referrals and authorizations - 877-890-8203
- Routine referrals and authorizations - 877-890-9309

To fax a Referral/Authorization Request Form to UnitedHealthcare (automated fax transmission or paper fax) to the assigned number, you may download either a PDF form that you can complete online and then print, or you can print and complete the form by hand. Both forms are available at UHCMilitaryWest.com > Providers > Find a Form > Medical-Surgical Referrals & Authorizations.

UnitedHealthcare staff reviews referral/authorization requests in order to:

- Determine the beneficiary’s TRICARE eligibility
- Determine if the care request is supported by an approved PCM referral (for Prime beneficiaries only)
- Verify that the service requested is a TRICARE covered benefit
- Determine if the service is medically necessary and is at the appropriate level of care
- Determine if the service requested can be provided by an MTF and send the beneficiary to the MTF, if available (this would be considered a ROFR and is only applicable for non-active duty Prime beneficiaries.)
- Locate a network civilian provider (if a network provider cannot be located, a non-network provider may be authorized if no specific provider is indicated on the request)
- Notify the beneficiary, the servicing provider, and the requesting provider that the referral has been completed when applicable as set forth in the TRICARE Operations Manual

The best way to submit your request form is through UHCMilitaryWest.com > Providers. The secure portal ensures that every submission includes all required fields, and there are no issues due to hand-writing, fax quality, or outdated versions of the request form. However, if a manual fax is necessary, the review process is expedited when referral/authorization requests include all information required and the Referral/Authorization Request Form is completed in a legible manner. Submit medical documentation whenever necessary to fully describe beneficiary’s condition and the need for services.

UnitedHealthcare determines whether the request can be processed or if additional information is required. Network providers must be used if available. Non-network providers will not be authorized without review.

UnitedHealthcare Military & Veterans Prior Authorization Requirements

You must receive prior authorization for requested services, procedures, or admissions that require medical-necessity review (on the Prior Authorization List) prior to services being rendered. The Prior Authorization List is available online at UHCMilitaryWest.com > Providers > Referrals and Prior Authorizations. This online list has a link to a list of service codes that require authorization. The frequency of updates for this list of service codes varies (as frequently as monthly) as new service codes are approved for industry use or retired or replaced.

Providers are required to:

- Secure an authorization for all procedures listed on the Prior Authorization List for all TRICARE beneficiaries in programs administered by UnitedHealthcare, including TRICARE Prime, TPR, TPRADFM, Standard, Extra, TRS, TRR, TYA, and ECHO.
- Secure a prior Authorization for ADSMs -For ADSMs, referrals from the MTF or R&SMSO-GL and prior authorizations are required for all inpatient and outpatient services from a civilian network or non-network provider. This is to ensure ADSMs continue to meet fitness-for-duty requirements. Providers who do not obtain a prior authorization when it is required, or who exceed the scope of an approved prior authorization, risk having payment for the service reduced or denied. Submit authorization requests with supporting clinical
documentation for these services. This is important to provide for the MTF review that happens on every civilian-submitted request.

Please note Line of Duty eligibility must be determined by R&SMSO-GL or the beneficiary’s current duty location.

**Prior Authorization and OHI**

When a beneficiary has other health insurance (OHI) as their primary coverage, pre-authorization requirements do not apply (except for Residential Treatment for Behavioral Health and ECHO Services, ABA services, in-patient behavioral health, DME exceeding $150, and transplants). Any medical necessity reviews UnitedHealthcare deems appropriate in order to act as a secondary payer shall be performed on a retrospective basis.

**Referral and Appointment Process**

The beneficiary will be notified via letter to schedule his or her own appointment with the specialist. The letter is mailed within one business day of approval and includes:

- Requesting provider’s name
- UnitedHealthcare reference number
- MTF tracking number, called a Unique Identification number (UIN), which consists of the Julian date of the request (six digits), and the DMIS code (four digits) and a system generated unique number. If a request is from a civilian provider, there is no MTF order number.
- Specialist’s name, office address, and office telephone number
- Service date range, which is the time frame in which the appointment must be obtained by the beneficiary
- Reminder that the beneficiary can track the status of his or her referral or authorization request online, if registered at UHCMilitaryWest.com
- Instructions to change servicing provider, when applicable

**Note:** In the case of an urgent or emergency request, no notification is sent to the beneficiary.

Beneficiaries have the right to choose a different servicing provider by contacting UnitedHealthcare. The approved servicing provider should wait for the beneficiary to call to make an appointment. Two important rules must be followed here:

1. The original referral/authorization must not have been used, and
2. The ability to change the provider is dependent on the type of authorization.
   a. If the authorization number begins with a “7,” the beneficiary does not need to notify UnitedHealthcare of a change in provider.
   b. If the authorization number begins with a “4,” the beneficiary must contact UnitedHealthcare at 877-988-9378 to request that a new authorization be generated for the provider selected.

The date span of the authorization can be found on the approval letter, and is subject to TRICARE eligibility. Issuance of a referral does not guarantee payment by TRICARE. If the beneficiary needs specialty care within 72 hours or less, or for an urgent issue, the appointment process must be expedited from provider to provider. When providers expeditiously arrange appointments, it is still necessary for the PCM to complete the referral form process so a tracking number can be issued.

Providers who are registered users at UHCMilitaryWest.com may check the status of referral/authorization requests online, view the documentation submitted by the requesting provider, and review the outcome of the care request process.

Beneficiaries may also register for the secure website to check the status of their referral/authorization requests. It is possible that a beneficiary may learn the status of his or her request before the referring and servicing providers receive the approval letter from UnitedHealthcare.

**Requesting Additional Services**

When requesting additional services a new care request must be submitted. If you are not able to use the Provider Portal, the Referral/Authorization Request Form may be used. The manual form is available at UHCMilitaryWest.com > Providers > Find a Form > Medical-Surgical Referrals & Authorizations > Referral/Authorization Request Form.
TRICARE Prime, TPR, and TPRADFM beneficiaries are required to have a referral from their PCM or an MTF for most specialty care services. If there is no referral from a PCM or the MTF to the civilian specialty provider within 180 calendar days (or the time period noted in the initial referral) of the request for services submitted by that civilian specialty provider, a request from that civilian specialty provider will not be approved. When the care is not approved, the beneficiary, the requesting civilian specialist, and the PCM will receive a notification from UnitedHealthcare stating the beneficiary must contact his or her PCM or MTF to obtain a specialty referral. The beneficiary has the right to use the POS option for self-referred services at any time. Please refer to the TRICARE Prime Point-of-Service Option (POS) section for more information.

To determine whether the PCM or the servicing provider should request the referral or authorization, follow these guidelines:

- If the additional services required are for the same course of care as the initial referral to that specialist and there is a PCM referral for this diagnosis within the last 180 calendar days (or the time period noted in the initial referral), the specialist can request the referral to a second network specialist. Note that the request will still be subject to ROFR if the MTF has the capability to provide those services.
- If it is not the same as the initial course of care, a TRICARE Prime beneficiary needs to be directed back to his or her PCM.

Please review the following examples (please note that this is not an exhaustive list of scenarios):

- A TRICARE Prime beneficiary is referred to a cardiologist by his or her PCM within the last 180 calendar days (or the time period noted in the initial referral). The cardiologist determines that cardiovascular surgery is necessary. The cardiologist submits a request to UnitedHealthcare for a referral to a cardiovascular surgeon. The cardiologist’s consult report would indicate the need for a second specialist. The consult report would keep the PCM aware of the need for a second specialist and the beneficiary’s condition, but there is no need for the beneficiary to return to his or her PCM to obtain the referral. The referral would be subject to ROFR if the MTF has the capability to provide the cardiovascular surgery.

- A TRICARE Prime beneficiary is referred to a cardiologist by his or her PCM within the last 180 calendar days. The cardiologist determines during the consultation that the beneficiary has tested positive for type 2 diabetes, which requires the services of an endocrinologist or the PCM. In this case, the beneficiary should be directed back to the PCM who will either manage the care or request a referral from UnitedHealthcare for the appropriate specialty because the course of care has changed.

- A TRICARE Prime beneficiary is referred to an orthopedist by his or her PCM but the PCM referral has since expired. It is determined that the beneficiary needs to have an MRI and physical therapy. The orthopedist requests the additional referral from UnitedHealthcare. UnitedHealthcare will send letter indicating that request may be subject to POS charges due to absence of PCM referral.

Providers should review the determination letter and/or care request outcome online from UnitedHealthcare that is sent in response to the referral or authorization request.

The referral/authorization determination letter will provide the date range for which services have been approved. If services cannot be provided within that date range, a new referral from the PCM or MTF is required to avoid higher out-of-pocket costs for the beneficiary and potential delays in care.

For additional information on the referral process, go to UHCMilitaryWest.com > Providers > Referrals and Prior Authorizations.

Checking Referral and Authorization Status Online

Providers may check the status of referrals and authorizations in the secure area of the UnitedHealthcare website. Access to this feature is available only to providers who have registered on UHCMilitaryWest.com. Providers may view the status of referrals and authorizations that they have requested and for which they are the servicing provider.

The information available includes the beneficiary’s information, the date the request was received by UnitedHealthcare, services requested and their status.
Prior Authorization
The request for certain medical, surgical, and behavioral health care services is reviewed to confirm medical necessity and appropriateness of care prior to services being rendered (or within 24 hours of an emergency admission unless otherwise specified in the provider’s contract). Refer to UHCMilitaryWest.com for the current Prior Authorization List (PAL), which lists all services requiring prior authorization. A prior authorization is required for requested services, procedures, or admissions that require medical necessity review prior to services being rendered. Specialists are required to obtain authorizations before performing any procedure for a TRICARE Prime beneficiary.

The PAL is available online at UHCMilitaryWest.com > Providers > Referrals and Prior Authorizations > Prior Authorization.

Authorizations are required for all procedures listed on the PAL for all TRICARE beneficiaries in programs administered by UnitedHealthcare, including TRICARE Prime, TRPR, TRPRADF, TRICARE Standard and TRICARE Extra, TRS, TRR, TYA, and ECHO. Providers must submit authorization requests with supporting clinical documentation for these services. When using the fax process, please include the clinical information along with the Referral/Authorization Request Form. If the clinical information received is insufficient to make a determination, the provider will receive a fax (or telephonic request) for additional information. The required information must be returned within 24 hours to avoid delays in beneficiary care.

Prior Authorization Not Required
The following is a partial list of services that do not require authorization. Please note that this list is not exhaustive:

- Annual Pap smear
- Cardiac stress tests and myocardial imaging
- Colonoscopy—screening and diagnostic
- CT scans (Screening is not covered.)
- Dexa scans (Screening is not covered.)
- Eight routine outpatient mental health visits per beneficiary, per fiscal year (See the Behavioral Health Care Services section of this Handbook for additional details.)
- Emergency room services
- Esophagastroduodenoscopy
- Eye examinations
- Intravenous pyelogram
- Labs (except for genetic testing, which requires authorization)
- Mammograms—annually for women beginning at age 40 (Covered annually beginning at age 30 for women who have a 15 percent or greater lifetime risk of breast cancer. For more information, see Covered Services in the Medical Coverage section of this Handbook.)
- Pulmonary function test
- Radiographs
- Specialized scans, (e.g., PET scans, except as noted in prior sections as unproven.)
- Ultrasounds—only covered if medically necessary (Screening to determine the baby’s sex is not covered.)
- Upper gastrointestinal studies

Prior Authorization for ADSMs
For ADSMs, referrals from the MTF or R&MSMO-GL and prior authorizations are required for all inpatient and outpatient services from a civilian network or non-network provider. This is to ensure ADSMs continue to meet fitness-for-duty requirements. Providers who do not obtain a prior authorization when one is required, or who exceed the scope of an approved prior authorization, risk having payment for the service reduced or denied.
Prior Authorization for TRICARE Standard and TRICARE Extra Beneficiaries

Providers treating TRICARE Standard and TRICARE Extra beneficiaries are required to obtain authorization before performing the procedures on the PAL available at UHCMilitaryWest.com.

Prior authorization from TRICARE is not required when the beneficiary has OHI that covers the treatment required, except as indicated in the TRICARE and Other Health Insurance (OHI) section of this Handbook. If the OHI does not cover a service or procedure that TRICARE does cover, submit a statement from the OHI indicating that the OHI does not cover the service along with your request to UnitedHealthcare. This will help prevent delays.

Avoiding Referral/Prior Authorization Request Delays

The following guidelines will help expedite your referral and authorization requests. The best way to submit your request form is via the UHCMilitaryWest.com Provider Portal. The portal ensures that every submission includes all required fields, and there are no issues due to hand-writing, fax quality, or outdated versions of the request form. However, if a manual fax is necessary:

- Use the approved Referral/Authorization Request Form from UHCMilitaryWest.com for any TRICARE Prime beneficiary requiring a specialty care referral or a prior authorization for any TRICARE West Region beneficiary who requires prior authorization for services on the PAL.

- Fax referral and authorization requests with physician documentation and all clinical indications, including laboratory/radiology results related to the requested service. Attach relevant documentation to your fax request. Submit a complete and legible Referral/Authorization Request Form by fax.

- Be specific about the requested services and provide the most appropriate procedure and diagnosis codes. Requests for DME also require complete information on applicable codes. A reasonable range is acceptable. Include National Drug Codes for medication requests.

- Make sure the correct ICD-10 code is included. Include pertinent clinical documentation for services on the Prior Authorization List.

- Be sure to clearly reference your contact information, particularly the fax number to which UnitedHealthcare should respond. Incomplete forms may slow the process.

- Pictures sent via fax do not transmit clearly and may delay the process while UnitedHealthcare requests and awaits receipt of originals. If you mail hard copies of photographs and wish to have them returned to your office after the authorization is approved, please indicate so when you mail the photographs to UnitedHealthcare. Otherwise, after the requested procedure is approved, the mailed photos may be destroyed.

- The date span approved for any referral or authorization will be indicated on the approval letter. Often, the date span will default to 180 calendar days from the first date approved, but can vary based on the service or specialty requested. If the servicing provider is unable to provide the approved services prior to the expiration of the referral, a new referral/authorization request must be submitted. After the approved date span, the PCM must request a new referral/authorization.

- If additional units are needed for an existing request, the provider will need to submit a new request.

- Verify the beneficiary’s demographic information (e.g., sponsor’s SSN or DBN, address, date of birth) and include it on the request form.

- When faxing, you only need to fax your referral or authorization request once, if you have confirmed that you faxed the referral to the correct number and have a confirmation from your fax machine. Re-faxing creates duplicate requests and delays processing. You may check the status of your request online at any time if you are registered with UHCMilitaryWest.com.

- When faxing, Referral/Authorization Request forms should be faxed with individual cover sheets. Submitting multiple referrals or authorizations under one fax cover sheet (batch faxes) will not be processed due to the risk of inadvertently releasing improper PHI or PII.
• Please do not ask for more than one specialty referral per request form or portal submission. This will result in a faxback to the requesting provider. Approved referrals are sent via US mail. You may also obtain the status of services for which you are the approved servicing provider 24 hours a day, seven days a week online if you are registered with UHCMilitaryWest.com.

• Remember to submit the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes for services requested. Experience shows that additional services are commonly requested, subsequent to the initial request and UnitedHealthcare typically approves the most common services and units as an Episode of Care (EOC) on the original referral. In such cases, more services may be approved than requested and providers should only provide the medically necessary services from that list of services.

• When completing the ‘Provider Rendering Care’ section of the Referral/Authorization Request form, be sure to complete all data elements; including name, NPI, address, specialty, sub-specialty (if applicable), office phone number, and office fax number.

For requesting providers: If you have not received confirmation of the referral or approval of the authorization, please assure your patients that medically necessary, covered benefits will be authorized and reimbursed.

For providers receiving referrals/authorizations directly from the requesting provider: If you receive communication from the requesting provider that the referral or authorization has been submitted, please wait for the confirmation that the service has been approved as a covered benefit. All medically necessary and covered benefits for eligible beneficiaries will be authorized and reimbursed. You may check the status of services for which you are the requested servicing provider online if you are registered with UHCMilitaryWest.com. If you are not the requesting provider, or you are not registered to view the status online, you may contact UnitedHealthcare at 877-988-9378.

Note: Prior authorization is not a guarantee of payment.

ECHO Prior Authorization
Providers must request prior authorization for all ECHO services. Refer to the TRICARE Program Options section of this Handbook for more information about the ECHO program.

UnitedHealthcare Penalties for Non-compliance

Network Providers
TRICARE claims submitted to PGBA without the required authorization are reviewed and, if determined to be medically necessary and for a covered benefit, reimbursed at the TRICARE-allowable charge with an assessed penalty. Providers may not bill the beneficiary the penalty amount. If the beneficiary did not advise the provider of TRICARE coverage before services were rendered, the provider may request a post-service, prepayment review from UnitedHealthcare. The request and related information/documentation may be submitted to:

TRICARE West Region
Correspondence Department
P.O. Box 7065
Camden, SC 29021 -7065

Non-Network Providers
TRICARE claims submitted to PGBA without the required authorization are denied.

Medical Necessity Review Requirements
A TRICARE beneficiary may need a procedure that requires a medical necessity review. A medical necessity review determines if the procedure requested is the appropriate and necessary treatment for the beneficiary’s illness or injury according to accepted standards of medical practice and TRICARE policy. UnitedHealthcare utilizes the TRICARE Operations Manual the TRICARE Policy Manual, MCG®, Medicare Guidelines, Milliman Care Guidelines, and UnitedHealthcare Policies to determine medical necessity for prior authorizations. All TRICARE providers in nonemergency settings are required to obtain an authorization for procedures included on the PAL. Providers may access the PAL at UHCMilitaryWest.com > Providers > Referrals and Prior Authorizations. The PAL is subject to change.
Note: Prior authorization is not a guarantee of payment.

Referrals, Authorizations, and OHI
With the exception of DME, behavioral health, ECHO and Autism services, referrals and authorizations are not required for TRICARE-covered procedures when the beneficiary has OHI that covers the rendered service, except as indicated in the TRICARE and Other Health Insurance (OHI) section of this Handbook. For example, even if the beneficiary has OHI, authorization is required for any behavioral health treatment outside of the initial eight self-referred visits per fiscal year. See the Behavioral Health Care Services section of this Handbook for more information.

All of the following apply when a TRICARE beneficiary has OHI:

- The procedure must be a covered benefit of the OHI, and all of the rules of the primary insurance must be followed; otherwise, TRICARE does not participate in the claim. However, if it is an excluded benefit under the OHI, once a denial for the exclusion is obtained, it will be covered by TRICARE if it is a TRICARE covered benefit.
- Active duty service members receiving care under TPR or the Supplemental Health Care Program (see the TRICARE Program Options section of this Handbook) are not subject to coordination-of-benefit rules.

DME, Behavioral Health, ECHO and Autism care requests should be submitted independent of the OHI status of the beneficiary. See the Claims Processing and Billing Information section of this Handbook for more information about coordinating benefits between TRICARE and OHI. TRICARE is always the primary payer for ADSMs.

Consult Report Tracking
Providers must submit their specialist reports (e.g., consultation reports, discharge summaries, operative reports, therapy reports, imaging study reports, reports regarding any additional procedures or skilled therapies, final reports) to the referring provider or MTF within 30 working days of the specialty encounter. Preliminary reports for urgent and emergency services are due within 24 hours unless otherwise specified in the provider’s contract, and the final report is due within 10 working days. The intent is to facilitate appropriate continuity of care for all TRICARE beneficiaries. Both civilian and MTF referring providers need feedback to properly manage their patients’ care. For active duty service members, this will be shared with the MTFs and R&SMSO-GL to assist them in assuring that the active duty service members are ready for duty.

The MTF fax number for consult tracking document submission can be found on the approval letter. Providing consult reports improves quality of care for patients. It also improves coordination of care between the MTF and civilian providers. Having a complete medical record is necessary for the military to assess troops’ combat readiness and fitness for duty.

Report Tracking Procedures for Referrals
Approved referrals will be entered into UnitedHealthcare’s medical management system. Approval notifications will be sent to the beneficiary, the PCM, and the specialist.

The beneficiary approval letter contains:

- Information on the service(s) approved
- A tracking number
- The name and contact information of the specialist

The communication to the specialist includes a copy of the beneficiary letter and the referral/authorization approval letter. The original request document (physician’s order) is included with the letter.

If you must mail your report, mail it to the referring provider, which includes the referring MTF, and include the fax cover sheet. This will aid in the process of sending reports to the referring provider and placing reports in the beneficiary’s medical record in a timely manner.

Report Tracking Follow-Up Process
Each MTF in the region will be following up to collect consult reports. It is imperative for the provider of the service to comply and submit the report to the MTF within 10 business days after the visit and upon contact from the MTF requesting the consult report.
Providing Care to Beneficiaries from Other Regions

Emergency and Urgent Care

Under all TRICARE programs, no referrals or authorizations are required for TRICARE beneficiaries receiving emergency care in or out of their TRICARE regions. However, TRICARE Prime beneficiaries are instructed to contact their PCMs or regional contractors (e.g., UnitedHealthcare; Health Net Federal Services, LLC; Humana Military Healthcare Services, Inc.) within 24 hours of an inpatient admission or the next business day to coordinate ongoing care.

TRICARE Prime beneficiaries must receive referrals from their PCMs or regional contractors for urgent care centers. If a TRICARE Prime beneficiary does not receive a referral, the claim will be paid under the POS option. If you provide emergency or urgent care services to a TRICARE beneficiary from a different region, the beneficiary will be responsible for payment of the applicable copayment or cost-share, and you will submit claims to the region where the beneficiary is enrolled, not the region in which he or she received care. See the Claims Processing and Billing Information section of this Handbook for more information.

Note: If the condition that prompted the emergency care is found to be routine and there is no evidence that the condition ever appeared to be anything other than routine, the care will be covered under the POS option for TRICARE Prime beneficiaries. Exceptions are made if the beneficiary was referred to the emergency department by his or her PCM or regional contractor.

If you have questions about processing claims for beneficiaries from other regions, contact UnitedHealthcare at 877-988-9378.

Routine Care

TRICARE beneficiaries are instructed to receive all routine care, when possible, from network providers in their designated regions. However, in some cases, beneficiaries will receive routine care in another region. In such cases, the following guidelines apply:

- TRICARE Standard beneficiaries will pay applicable cost-shares, and providers will submit claims to the region where the beneficiary resides, not the region in which he or she received care.
- TRICARE Prime beneficiaries will receive referrals from their PCMs or regional contractors for out-of-region care and will pay applicable copayments. Providers will submit claims to the region where the beneficiary is enrolled, not the region in which he or she received care in the continental United States. See the Claims Processing and Billing Information section of this Handbook for more information. If a TRICARE Prime beneficiary does not receive a referral for out-of-region care, claims will be paid under the POS option.

If you have questions about processing claims for beneficiaries from other regions, or care rendered outside the continental United States, contact UnitedHealthcare at 877-988-9378.

Medical Records Documentation

Providers must maintain clinical and other records related to individuals for whom payment was made for services rendered by the provider, or otherwise under arrangement, for a minimum of 60 months from the date of service, or the longer period specified in your agreement or by state law.

UnitedHealthcare may review your medical records on a random sample 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 chart is appropriately organized and that confidentiality of the beneficiary’s information is maintained. The medical record must be kept current, and must substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment.

Providers must also permit access by Deputy Director, DHA, or his designee to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state, private agencies or organizations.

Guidelines for Medical/Surgical Care

The following guidelines will assist you in documenting medical and surgical care in every individual patient record:

- The record should be legible to someone other than the writer.
- Every page in the record must contain the beneficiary’s name or ID number.
• Personal/biographical data should include address, employer, home and work telephone numbers, and marital status.

• All entries in the medical record must contain author ID, which may be a handwritten signature, unique electronic identifier, or initials.

• All entries must be dated.

• Significant illnesses and medical conditions must be indicated on a problem list.

• Medication allergies and adverse reactions, if any, should be prominently noted in the record.

• Medical history (for beneficiaries seen three or more times) should be easily identifiable and include serious accidents, operations, and illnesses.

• For children and adolescents (age 18 and younger), medical history should relate to prenatal care, birth, operations, and childhood illnesses.

• For beneficiaries age 12 and older who have been seen three or more times, information concerning use/abuse of cigarettes, alcohol, and controlled substances should be noted.

• Histories and physicals should contain appropriate subjective and objective information for presenting complaints.

• Laboratory and other studies should be ordered, as appropriate, and documented properly.

• Working diagnoses should be consistent with findings.

• Treatment plans should be consistent with diagnoses.

• Encounter forms or notes should include a notation, when indicated, regarding follow-up care, calls, or visits, and the specific time of return should be noted in weeks, months, or “as needed.”

• Unresolved problems from previous office visits should be addressed in subsequent visits.

• Reviews should be conducted for underutilization or overutilization of consultants.

• Consultant notes/results for a requested consultation must be entered on the chart.

• To signify review, all consultation, laboratory, and imaging reports filed in the chart should be initialed by the ordering practitioner. Review and signature by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, review by the ordering practitioner should be documented.

• Consultation, abnormal laboratory, and imaging study results should include an explicit notation of follow-up plans in the record.

• Individual records must be used to demonstrate whether the care was needed and if it was of such quality to meet the beneficiary’s needs.

• Immunization records for children must be up to date, and an appropriate history must be made in the medical records for adults.

• Evidence that preventive screening and services were offered and accepted or rejected in accordance with the office’s practice guidelines should be included in the record.

• In cases of unusual deaths, or in deaths of medical-legal and educational interest, there should be documentation of request (consent or refusal) for an autopsy.

• Medical record documentation of injection(s) should include:
  ‣ Name of drug
  ‣ Lot number
  ‣ Time of administration
Dosage
Route of administration
Site of injection
Signature or initials of individual administering the medication
For immunizations: lot number, manufacturer, verification that the Vaccine Information Statement was given to the patient or parent/guardian, and the name and address of the health care provider administering the vaccine

Guidelines for Medical/Surgical Care Specialists and Service Providers
A provider may refer a TRICARE beneficiary to a specialist to obtain an opinion, advice, or specialty care services. In the case of a beneficiary enrolled in TRICARE Prime, a referral must be obtained through UnitedHealthcare. The specialist’s treatment or findings, along with results of any services rendered, must be documented in the beneficiary’s record.

To help promote continuity of care, all TRICARE network specialty and servicing providers are responsible for communicating the results of an examination and/or treatment to the referring civilian or military provider, who is usually the beneficiary’s PCM, within 10 working days. For more information, refer to Consult Report Tracking earlier in this section.

Inpatient Admission Notification
Providers are required to notify UnitedHealthcare within 24 hours of an emergency admission unless otherwise specified in the provider’s contract. Admissions resulting from a psychiatric emergency should be reported to UnitedHealthcare within 24 hours of the admission or the next business day after the admission, but must be reported within 72 hours of the admission. Medical/surgical admission and maternity notifications should be faxed with face sheets to 877-578-2738, or notifications can be called into 877-988-9378. This also applies to weekend notifications. Notification of outpatient observation is not required. Emergency Psychiatric admissions may be reported by faxing a completed Inpatient Emergency Admission—Mental Health form (UHCMilitaryWest.com > Providers > Find a Form > Behavioral Health) to UnitedHealthcare at 877-581-1590 for routine requests, or 877-579-8589 for urgent requests.

Utilization Management
Utilization Management is a process of prospective, concurrent, or retrospective reviews that evaluate the medical necessity and appropriateness of beneficiary medical care.

Prospective Review
Prospective review is conducted on a pre-service basis when a procedure or service requires a medical necessity review. The review is performed under the direction of a registered nurse, physician assistant, behavioral health clinician, or physician, and its purpose includes the following:

• Determining medical necessity
• Evaluating proposed treatment
• Assessing level of care required
• Determining appropriate level of care prior to admission
• Identifying potential for discharge-planning needs and determining whether the case meets care-coordination or case-management criteria
• Identifying potential quality-of-care issues

Note: First-level reviewers may issue denial determinations based on coverage limitations contained in 32 Code of Federal Regulations (CFR) 199, the TRICARE Policy Manual, and other TRICARE guidance (these are considered factual determinations) or refer the case to second-level review. Physicians who did not participate in the first-level review of the care under consideration conduct second-level reviews.
Concurrent Review

Concurrent review is a process of continual reassessment of the beneficiary’s needs during an inpatient stay. Upon admission, UnitedHealthcare’s Clinical Services will accept concurrent review information provided by the admitting physician or other health care professional and/or the hospital’s Utilization Review department.

Furthermore, if not already submitted, the facility will provide us with the discharge plan on the day of admission.

The continued stay for all inpatient admissions must be certified through the concurrent review process. Upon request, the provider must submit to UnitedHealthcare by phone or fax sufficient clinical information to justify the continued stay and to allow the review of the beneficiary’s medical status during an inpatient stay, extend the beneficiary’s stay, coordinate the discharge plan, determine medical necessity at an appropriate level of care, and identify case management candidacy.

The provider must respond to inquiries from UnitedHealthcare and provide complete clinical information and/or documents as required within four hours if our request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).

UnitedHealthcare uses MCG™ Care Guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings.

Retrospective Review

A retrospective review is a review of the beneficiary’s medical record that occurs after the services have been rendered. The review may be performed as part of the quality-management process or during the claims verification.

Diagnosis-related group (DRG) validation is conducted on a 1 percent sample of DRG-reimbursed claims. Cases by facilities are randomly reviewed and audited. The complete medical record is requested for verification of level of care determination, verification of diagnostic and procedural coding, and validation of appropriate reimbursement for the claim. Technical denials are issued when complete medical records are not received within 30 days.

Payment adjustments are made when errors are identified during the DRG-validation audit.

Review Activities – Institutional Providers

With regard to institutional network provider only, the TRICARE program requirements specify the following:

Institutional providers must cooperate with UnitedHealthcare in the assumption and conduct of review activities, allocate adequate space for the onsite review, and photocopy and deliver to UnitedHealthcare all of the required information within 30 calendar days of a request for an off-site review. UnitedHealthcare shall reimburse the provider for the costs of photocopying and postage using the same reimbursement as Medicare.

Institutional providers must inform UnitedHealthcare within three working days if they issue a notice that the beneficiary no longer requires inpatient care. They will assure that each case subject to preadmission or preprocedure review has been reviewed and approved by UnitedHealthcare.

Institutional providers will provide all beneficiaries, in writing, their rights and responsibilities (e.g., “An Important Message from TRICARE” and “Hospital Issued Notice of Noncoverage”).

If an institutional provider fails to obtain the required certification, they then accept full financial liability for any admission subject to preadmission review that was not reviewed, and is found to be medically unnecessary or provided at an inappropriate level.

Care Coordination

Care coordination is a comprehensive method of assessment designed to identify beneficiary vulnerability, needs, and goals that results in the development of an action plan to produce an outcome that is desirous for the beneficiary. The goal is to provide patient advocacy, a system for coordinating client services, and a systematic approach to evaluation of the effectiveness of the beneficiary’s health maintenance.

TRICARE West Region care coordination identifies and assists TRICARE beneficiaries with post-service needs.

The care coordination process is monitored through concurrent review activities, which assess and identify potential care coordination, demand management, discharge needs, and case management candidates.
TRICARE Quality Monitoring Contractor

KePRO is the TRICARE Quality Monitoring Contractor (TQMC) and will assist DoD Health Affairs, the DHA, MTF market managers, and the TRICARE Regional Offices by providing the government with an independent, impartial evaluation of the care provided to beneficiaries within the MHS. The TQMC will review care provided by TRICARE authorized/certified providers in addition to other TRICARE contractors and subcontractors on a limited basis. The TQMC is part of TRICARE’s Quality and Utilization Peer Review Organization Program, in accordance with 32 CFR 199.15. Providers may contact KePRO by any of the following means:

| Mail     | KePRO  
|----------|--------
|          | ATTN: TRICARE Operations  
|          | 777 East Park Drive  
|          | Harrisburg, PA 17111  
| Phone    | 877-841-6413  
| Email    | tricare@kepro.com  

Medical records will be requested from the regional contractor on a monthly basis to comply with requirements detailed in the *TRICARE Operations Manual*, Chapter 7, Section 3 at manuals.tricare.osd.mil. Your facility may be required to submit records to meet those requirements. Should you receive a request letter, you are required to submit the entire medical record that was requested. Failure to do so will result in recoupment of payment for the hospitalization and/or any other services for which you were paid in accordance with 32 CFR 199.4(a)(5).

**Clinical Quality Management (CQM)**

UnitedHealthcare has established the Clinical Quality Management Program (CQMP) to develop, recommend, implement, and continuously evaluate the continuum of the medical, surgical, and behavioral health care services delivered to TRICARE-eligible beneficiaries. The CQMP is designed to identify areas where care can be improved and to provide feedback to physicians and providers in such areas as:

- Providers’ clinical performances
- Practice patterns
- Eligibility for retention in the network
- Availability aspects of service delivery

UnitedHealthcare reviews network and non-network providers when evaluating the delivery of health care services. This process includes identifying potential patient safety and quality-of-care issues, identifying opportunities for improvement, and implementing corrective action plans. UnitedHealthcare reviews physicians and other providers to assess quality and cost efficiency of the health care services provided.

**Provider Participation**

Providers are required to participate in CQM activities in accordance with federal laws. TRICARE providers must agree to follow all established quality assurance procedures; that is, they must make medical and other pertinent records available to UnitedHealthcare.

Activities that are related to the CQM process include, but are not limited to:

- Participating in the investigation of grievances
- Providing access to data for quality studies
- Complying with peer review, utilization review, and quality programs and procedures established by UnitedHealthcare or TRICARE, including:
  - Concurrent reviews
  - Retrospective reviews
  - Discharge planning for inpatient admissions
  - Referral requirements (See *Referrals and Authorizations* earlier in this section.)
 › Allowing UnitedHealthcare and its designees to have access to provider records within a reasonable time and providing complete medical records upon request
 › Participating in audits regarding performance assessments of provider practices
 › Responsiveness to peer review communications and directed corrective actions

**Potential Quality Issue Review**
The UnitedHealthcare CQMP oversees all care delivered under the TRICARE program and is required, at a minimum, to assess every medical record reviewed for any purpose and any care managed, observed, or monitored on an ongoing basis for potential quality issues in accordance with the following:

- Inpatient stays
- Medical or surgical visits
- Behavioral health facility
- Office visits
- Skilled nursing

UnitedHealthcare will categorize potential patient safety or quality-of-care issues using the following categories:

**National Quality Forum’s Serious Reportable Events**
- Surgical or invasive procedure events
- Product or device events
- Patient-protection events
- Care-management events
- Environmental events
- Radiologic events
- Potential criminal events

**Agency for Healthcare Research and Quality Patient Safety Indicators**
- Death in low-mortality DRGs
- Decubitus ulcer
- Retained surgical item or unretrieved device fragment
- Iatrogenic pneumothorax
- Central venous catheter-related blood stream infection
- Postoperative hip fracture
- Postoperative hemorrhage or hematoma
- Postoperative physiologic and metabolic derangements
- Postoperative respiratory failure
- Postoperative pulmonary embolism or deep vein thrombosis
- Postoperative sepsis
- Postoperative wound dehiscence
- Accidental puncture or laceration
- Transfusion reaction
- Obstetric trauma—vaginal with instrument
• Obstetric trauma—vaginal without instrument

Deviation from Standard Practice Guidelines

• Inefficient care
• Quality of care

Providers may be contacted regarding a potential quality issue.

If you become aware of a potential quality issue while providing care to a TRICARE beneficiary, report the issue to UnitedHealthcare by completing a PQI Issue Referral form available at UHCMilitaryWest.com > Providers > Find A Form > Clinical Programs.

On-Site Provider Reviews

As part of UnitedHealthcare’s CQMP, UnitedHealthcare may conduct on-site evaluations of providers who have been targeted for further evaluation based on performance indicators. UnitedHealthcare may assist the provider in the development of an action plan to correct the area of concern.

Confidentiality

In accordance with federal law, all UnitedHealthcare employees who are engaged in CQM activities are required to maintain the confidentiality of information with which they deal. Individual practitioners or beneficiaries are to be referred to by number only, except when specific reference is necessary to meet the goals of the CQMP. All written records, reports or other work products, and communications related to CQM activities are considered privileged and confidential information.

Population Health Management

UnitedHealthcare’s approach to population management is designed to support all aspects of the Military Health Systems’ Quadruple Aim:

• Readiness: MTF efficiency -Impact Pro™ users access to network and direct care history, predictions and trends
• Population Health: Identification of population trends in health care: “Right Care-Right Time-Right Place”
• Positive beneficiary experience: Proactively identify those who will most benefit from CM programs and address gaps in care
• Responsible management of health care costs: integration clinically and financially of network and direct care

Using a two-fold approach, the Impact Pro tool is able to examine the needs of a population by using data to identify trends, create robust beneficiary profiles, and identify individual gaps in care.

Primary tool – Impact Pro™ (Predictive Modeling tool)

Impact Pro is a health care information solution that allows UnitedHealthcare and TRICARE West to gain a better insight into the factors that affect beneficiaries’ health and predict those at greatest risk for catastrophic medical or financial outcomes. Using up to 36 months of data, Impact Pro assists in understanding TRICARE West beneficiaries’ unique factors that are driving healthcare services by performing predictive modeling utilizing information available from enrollment files, medical claims (direct and purchased) and pharmacy claims, using a rolling last 12 months of data to predict the next 12 months of risk.

Impact Pro quantifies the relative risk between members based on a variety of factors. It takes into account demographic information such as age and gender and healthcare episodes, considers complications and co-morbidities as they increase risk, assigns risk factors and provides numeric scores of relative spending risk. Business rules are written within Impact Pro allowing UnitedHealthcare to identify gaps in care or opportunities to improve beneficiary care.

• The data is refreshed monthly
• Population Health has developed customized reports that provide for specific filter parameters
• Internal staff, MTF and TRICARE Regional Office-West (TRO-W) staff have been trained on the use of Impact Pro
Communication Outreach Program (Prime, Enrolled to the Network)

1. Cancer Screening Letters
   › Monthly letters are sent to beneficiaries who are due or past due for any one of the following screenings:
     - Colorectal screening
     - Cervical cancer screening
     - Breast cancer screening
   › Data source for list of beneficiaries to send letters comes from the Military Health System Population Health Portal (MHSPHP)

2. Reminder Brochures
   › Brochure/flyers are mailed to targeted beneficiaries who meet HEDIS like measures identifying gaps in care. They act as an alert (reminder) to encourage action on the following conditions:
     - Asthma medication (focusing on medication adherence)
     - Diabetes A1C test
     - Diabetes LDL cholesterol test
     - Diabetes retinal eye exam
     - Flu shot
     - Low back pain
     - Well-child exam
     - Depression (focusing on medication adherence)
     - Medication money saving tips
   › Data source is Impact Pro and data is mined monthly (although beneficiaries may receive only one reminder per targeted condition per year)

3. Gaps in Care – HealthyGlance Letters with Specific Messaging
   › Letters with up to more than 75 select messages tied to specific conditions for identifying potential “gaps in care”
     - Asthma
     - Coronary artery disease (CAD)
     - Congestive heart failure (CHF)
     - Chronic Kidney Disease
     - Chronic obstructive pulmonary disease (COPD)
     - Diabetes
     - Hyperlipidemia
     - Hypertension
     - Low back pain (sent in the form of brochure/flyer)
     - Depression (sent in the form of brochure/flyer)
   › No more than any of five messages per letter per beneficiary
   › Each unique message is mailed no more than twice annually to any beneficiary with accompanying letter to provider, however each month unique messages may be identified
› Provider of record is imputed from claims submitted over the last 12 months
› Data source is Impact Pro (with customized ‘suppression logic’ applied)

**Condition (Disease) Management**

UnitedHealthcare offers a beneficiary-centric Condition Management Program designed to help TRICARE West Region beneficiaries with specific conditions take a more active role in their own health care.

UnitedHealthcare’s Condition Management Program is a disease-specific approach to improving health care outcomes by providing one-on-one education to beneficiaries with a health coach registered nurse (RN), licensed respiratory therapist (RT), licensed clinical social worker (LCSW), Registered Dietician (RD), or pharmacist.

The Condition Management Program also offers nutrition counseling with registered dietitians. The program’s goal is to provide beneficiaries with skills to manage their health conditions. Health coach clinicians (RNs, RTs, RD, Pharm D, and LCSWs) work one-on-one with beneficiaries, providing support, educational materials and strategies to handle health challenges, as well as skills to improve their quality of life.

TRICARE Prime-eligible beneficiaries with one or more of the following conditions may benefit from participating in UnitedHealthcare’s Condition Management Program:

- Anxiety disorder
- Asthma (adults and children)
- Heart failure
- Diabetes (adults only)
- Depression
- COPD
- Cancer risk factors

Additional programs may be added periodically.

Beneficiaries are identified by the DoD on a bimonthly basis as candidates for a Condition Management Program. Only these beneficiaries are eligible for a Condition Management Program. The minimum criteria for program enrollment are one or more emergency room visits or one or more inpatient admissions with the listed primary diagnoses. UnitedHealthcare’s intensive portion of the program averages six to nine months in duration, depending on the amount of support and education the beneficiary requires. Then the beneficiary will go into the three month surveillance period to assess there are no further education needs and to review beneficiary progress and adherence to the program.

For more information about the Condition Management Program, please contact the Condition Management Department at 877-988-9378 or visit UHCMilitaryWest.com > Beneficiaries > Disease Management Program for health and wellness information.

**Health and Wellness**

To encourage beneficiaries to maintain or adopt healthy lifestyle habits, UnitedHealthcare offers health and wellness information at UHCMilitaryWest.com > Beneficiaries > Healthy Lifestyle. The information provided is available to all beneficiaries. There are also links to many DoD health improvement sites.

**Tobacco Cessation**

TRICARE offers a variety of services and benefits to support tobacco cessation.

**Counseling Services:** Smoking-cessation counseling is covered for all TRICARE beneficiaries age 18 and older who are not Medicare-eligible and who reside and receive counseling in one of the 50 United States or the District of Columbia. Counseling sessions must be conducted by a TRICARE-authorized provider. For more information, visit tricare.mil/quittobacco.

**UCANQUIT2.org:** All TRICARE beneficiaries can get smoking and smokeless tobacco-cessation support through DoD’s comprehensive Web site, www.ucanquit2.org. The site is part of DoD’s “Quit Tobacco—Make Everyone Proud” campaign. It offers interactive, online tobacco-cessation training, live support from trained tobacco cessation coaches, quit plan and calendar, text quit tips, savings calculator, games and other support services.
Smoking Cessation Medications: TRICARE covers smoking-cessation medications including prescription and over-the-counter (OTC) medications at no cost through MTF pharmacies and TRICARE Pharmacy Home Delivery. Smoking-cessation medications are not covered when purchased at retail pharmacies. TRICARE covers the following smoking cessation products when prescribed by a TRICARE authorized provider and acquired at an MTF or through TRICARE Pharmacy Home Delivery:

- Varenicline tablets (Chantix)
- Bupropion SR tablets (Zyban and generics)
- Nicotine nasal spray (Nicotrol NS)
- Nicotine inhalation (Nicotrol)
- Nicotine transdermal (Nicoderm CQ and Habitrol)
- Nicotine gum (Nicorette, Nicorelief and generics)
- Nicotine lozenge (Nicorette, Commit and generics)

TRICARE limits coverage of smoking-cessation medications based on “quit attempts.” Use of smoking-cessation medications for 120 days is considered one quit attempt. TRICARE covers two quit attempts each year, but may cover a third quit attempt with physician justification. If the beneficiary receives smoking-cessation counseling that overlaps with covered medication use by at least 60 days, it is considered a single quit attempt.

Quitline: Current smokers who want to quit or former smokers concerned about a relapse can speak with a trained smoking-cessation coach who will determine each individual's stage of the smoking-cessation process and inform the smoker about the availability of resources to quit smoking or remain smoke-free. Through the resources associated with the Smoking Quitline, callers can develop a quit plan to help them quit smoking or prevent a relapse. For information and support, call 888-713-4597, available 24 hours a day, seven days a week, including weekends and holidays.

Online resources: There are several online resources available to provide additional support and information: tricare.mil/quittobacco; ucanquit2.org

Prescription Monitoring/111 Programs
While providers usually have no direct involvement with the administration of the following programs, they may receive questions from beneficiaries who are enrolled in these programs and some basic knowledge may be useful.

The Prescription Monitoring Program for Active Duty Service Members, also known as the 111 Program for TRICARE beneficiaries, is a program designed to assist beneficiaries who may have “drug seeking behavior” or are at high risk of harming themselves through accidental overdose of narcotics or other high-risk medications. Through examination of pharmacy claims activity, at-risk beneficiaries may be identified and may receive communication that they will have certain restrictions on the pharmacy benefit. These restrictions may include:

- Restrict the beneficiary to all drugs to a specific pharmacy(s) and/or provider(s)
- Restrict controlled medications for a beneficiary to a specific pharmacy or list of pharmacies and/or providers or list of provider
- Exclude controlled medications or specific non-controlled medications through home delivery or at network pharmacies
- Restrict a beneficiary to one primary care manager/provider and one emergency department

if you have any questions, please contact the Prescription Monitoring Team at 866-333-1348.

Case Management
Case management takes a collaborative, integrated approach to managing the complex health care needs of an eligible beneficiary. Case management programs include medical/surgical and behavioral health case management, as well as specialty programs, such as cancer clinical trials, the TRICARE ECHO program, and transplants.

Case management is a process designed to assess, plan, implement, coordinate, monitor, and evaluate the options and services necessary to meet an individual's health care needs. Using communication and available resources to promote quality, cost-effective outcomes, case managers work one-on-one with the providers. UnitedHealthcare case managers act as beneficiary
advocates, working with multidisciplinary teams using clinical skills and knowledge to assure that the best possible care is provided.

Beneficiaries who have complex, catastrophic health care needs may benefit from the case management program. The beneficiary, a family member, or a provider can make referrals to case management by contacting UnitedHealthcare. An MTF or a member of UnitedHealthcare’s staff may also refer beneficiaries to case management. When a beneficiary is in case management, his or her case manager may provide multiple services, including:

- Identifying and facilitating needed services and equipment, and promoting the beneficiary’s self-care in collaboration with the PCM for optimal health care delivery and in conjunction with MTF and VA resources
- Decreasing the provider’s administrative tasks by assisting with referrals and authorizations and locating specialty providers
- Educating the beneficiary on TRICARE benefits and systems
- Identifying community resources
- Educating the beneficiary on his or her disease process and promoting lifestyle changes that can positively affect the management of the disease (e.g., compliance with the recommended treatment plan, adherence to medication regimen, keeping scheduled physician appointments)
- Providing a point of contact to assist with problem solving, acting as a beneficiary advocate, and assisting in communicating with caregivers on behalf of the beneficiary

The following may be appropriate for case management:

- Acute HIV/AIDS
- Admissions to a neonatal intensive care unit
- All residential treatment center admissions
- Behavioral health care admissions of children age 12 and younger
- Bone marrow procedures
- Burns (third degree or extensive second degree)
- Cardiovascular conditions
- ECHO registration
- Expected multiple births
- Head trauma
- History of intensive care for an infant
- Life-threatening suicide attempt
- Neoplasms and malignancy
- Neurological conditions involving intensive care or unconsciousness for more than 48 hours
- Obstetrical conditions that require hospitalization prior to delivery
- Participation in National Cancer Institute Phase I, II, or III cancer clinical trials
- Psychiatric residential treatment center admissions for adolescents
- Respiratory failure with new ventilator dependence post hospitalization
- Severely injured ADSMs
- Spinal cord injuries
- Transplants (organ, bone marrow, or stem cell)
- Two inpatient behavioral health care admissions within 90 days
To refer a TRICARE beneficiary to the program, download a Request for Case Management Services Form available on UHCMilitaryWest.com > Providers > Find A Form > Medical-Surgical Referrals & Authorizations.

**Fraud and Abuse**

Program integrity is a comprehensive approach to detecting and preventing fraud and abuse. Prevention and detection are a result 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 UnitedHealthcare staff.

DHA has a specific office to oversee the fraud and abuse program for TRICARE. The DHA Program Integrity (PI) Office is responsible for all anti-fraud activities worldwide for the Defense Health Program.

Some examples of fraud include:

- Agreements or arrangements between the provider and the beneficiary that result in billings or claims for unnecessary costs or charges to TRICARE
- Billing for costs of non-covered or non-chargeable services, supplies, or equipment disguised as covered items
- Billing for services, supplies, or equipment not furnished or used by the beneficiary
- 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 the identity of the recipient of the service or who provided the service
- Practicing with an expired, revoked, or restricted license, because an expired or revoked license in any of the United States or its territories will result in a loss of authorized provider status under TRICARE
- 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)
- Violation of the participation agreement that results in the beneficiary being billed for amounts that exceed the TRICARE-allowable charge or negotiated rate

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

Some examples of abuse include:

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

Providers are cautioned that 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 practice 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 is responsible for
providing legal counsel and legal services to the DHA Program Integrity Office. The DoD Office of Inspector General and other agencies investigate TRICARE fraud.

To anonymously report suspected fraud and/or abuse:

• Call the UnitedHealthcare Fraud Hotline at 888-899-5071
• Go online at www.dodig.mil/hotline

Please provide as much information as possible, including:

• Who committed the fraud
• When the fraud occurred (time frame)
• Where the fraud occurred
• Detailed description of the fraudulent activity.

For additional information, please refer to health.mil/fraud.

Grievances

If a provider or beneficiary has concerns about a level or quality of services or care received through the TRICARE program, the provider or beneficiary has a right to file a grievance with UnitedHealthcare.

A grievance is a written complaint on a non-appealable issue regarding a perceived failure by any member of the health care delivery team. Grievances may include such issues as:

• Appropriateness of care
• Availability of services
• Inappropriate behavior on the part of a health care provider or the provider’s staff
• The performance of any part of the health care delivery system
• Practices related to patient safety
• Quality of care
• Timeliness of services

Grievances received by UnitedHealthcare are reviewed to determine the proper course of action. To follow the formal grievance procedure, grievances must be submitted in writing and include any supporting documentation that may assist in reviewing the grievance. Grievances should be mailed to:

UnitedHealthcare Military & Veterans
Attn: Grievances
P.O. Box 105493
Atlanta, GA 30348
Fax: 877-584-6628

Grievances may also be submitted by fax to Appeals & Grievances at 877-584-6628 to the attention of the Appeals & Grievances department. This fax machine is located in a secure location within the Appeals & Grievances department, and confidentiality is assured. UnitedHealthcare reviews the grievance and provides a response within 30 calendar days from the date of receipt. If the grievance investigation and response cannot be completed within the allotted 30 days, an interim notice is mailed, with a final response to be completed within 60 calendar days.

If the individual who filed the grievance is dissatisfied with the outcome, he or she may request an additional review of the decision in writing.

Appeals

TRICARE beneficiaries and non-network participating providers have the right to appeal decisions made by UnitedHealthcare.

The appeals process varies, depending on whether the denial of benefits involves medical necessity determination, factual determination, or a provider sanction. All initial and appealed denials explain how, where, and by when to file the next level of
appeal. An appeal cannot challenge the propriety, equity, or legality of any provision of law or regulation. Appeal letters and documents may be mailed to:

UnitedHealthcare Military & Veterans
Attn: Appeals
P.O. Box 105493
Atlanta, GA 30348
Fax: 877-584-6628

For more information regarding appeals or grievances, go to UHCMilitaryWest.com > Beneficiaries > Claims > Appeals and Grievances.

**Proper Appealing Parties**

- The TRICARE beneficiary (including minors)
- The non-network participating provider (accepts assignment) of services
- A non-network participating provider (accepts assignment) appealing a preadmission/preprocedure denial (when services have not been rendered)
- 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 (this includes network providers with a signed Appointment of Representative for Appeal)
- An attorney filing on behalf of a beneficiary
- A custodial parent or guardian of a beneficiary under age 18

To avoid possible conflict of interest, an officer or employee of the U.S. Government, such as an employee or member of the uniformed services (including an employee or staff member of a uniformed services legal office), or a Beneficiary Counseling and Assistance Coordinator, subject to exceptions in Title 18, United States Code, Section 205, is not eligible to serve as a representative unless the beneficiary is an immediate family member.

**Medical Necessity Determinations**

Medical necessity determinations are based solely on whether, from a medical point of view, the care is appropriate, reasonable and adequate for the beneficiary’s condition. Generally, determinations relating to behavioral health benefits are considered medical necessity determinations. The appeal process for non-expedited medical-necessity determinations is listed below. There are expedited procedures for appealing decisions denying requests for prior authorization of services and requests for continued inpatient stays.

An expedited appeal is defined as a request to change an adverse determination for urgent care. Urgent care is any request for medical care or treatment with respect to which the application of the period for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgment
- In the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is subject to the request

If an expedited appeal is available, the initial and appealed denial decisions will fully explain how to file an expedited appeal.

- **Expedited appeal:** shall be received by UnitedHealthcare within three calendar days of the date of the receipt of the initial denial determination notification. Only the beneficiary, or the beneficiary’s representative, may request an expedited appeal.
• Non-expedited appeal: shall be received by UnitedHealthcare within 90 days of the date of initial denial determination notification.

Factual Determinations
Factual determinations involve issues other than medical necessity. Some examples of factual determinations include: coverage issues (i.e., determining whether the service is covered under TRICARE policy or regulation), foreign claims, and denial of a provider’s request for approval as a TRICARE-authorized provider. Factual determinations must be received by UnitedHealthcare within 90 calendar days of the date of the initial denial determination notification.

Provider Sanction Determinations
Providers who request approval as TRICARE-authorized providers, but are denied approval by either DHA or UnitedHealthcare, may appeal those decisions and request a reconsideration determination. Provider-sanction determinations occur when providers are expelled from TRICARE. Providers may be sanctioned by TRICARE because of failure to maintain credentials, provider fraud, abuse, conflict of interest, or other reasons. Only the provider or his or her representative can appeal. If the sanctions are appealed, an independent hearing officer will conduct a hearing administered by the DHA Appeals and Hearings Division. Providers who are not eligible for authorization by TRICARE because of fraud and abuse against another federal or federally funded program or a state or local licensing authority (e.g., Medicare or Medicaid) may not appeal through the TRICARE system.

Appeal Filing Deadlines
An appeal must be filed before the expiration of the appeal filing deadline or within 20 calendar days of the date of the contractor’s letter of notification of an improper appealing party filing. The letter of notification includes information for providers to submit these appeals. There must be a denial of an appeal due to untimely filing before an extension can be considered.

Levels of Appeals
Level 1. Request for reconsideration of the initial denial by UnitedHealthcare

Level 2. If the reconsideration results in the denial being upheld, then:
› Medical necessity-appeal to the TQMC, KePRO
› Factual-appeal to DHA

Non-Appealable Issues
• POS determinations, with the exception of whether services were related to an emergency and are, therefore, exempt from the requirement for referral and authorization
• Allowable charges (the TRICARE-allowable charge for services or supplies is established by regulation)
• A beneficiary’s eligibility, because this determination is the responsibility of the uniformed services
• Provider sanction (the provider is limited to exhausting administrative appeal rights)
• Network provider/contractor disputes
• Denial of services from an unauthorized provider
• Denial of a treatment plan when an alternative treatment plan is selected
• Denial of services by a PCM
• Denial of nonavailability statement (NAS) issuance
• Denial of registration into the ECHO program (if all eligibility criteria are not met)

Post-Service Prepayment Review (PSPR)
A PSPR is used to appeal a denial of payment for health care services that required an approval prior to being rendered. PSPR requests only apply to medical necessity issues after services have been rendered.

PSPR requests must be submitted in writing – either by the beneficiary or the non-network participating provider – to PGBA in order to receive TRICARE reimbursement. A PSPR does not apply to factual benefit determinations (e.g., if TRICARE does not
cover the service). A PSPR may be considered when neither the non-network participating provider nor the beneficiary could have reasonably known the service would be denied based on medical necessity or appropriateness.

A TRICARE beneficiary is not held liable for charges if the provider had prior knowledge that the services were excluded. Additionally, subject to application of other TRICARE definitions and criteria, the principle of waiver of liability is summarized as follows:

If the beneficiary did not know, or could not reasonably be expected to know, that certain services were potentially excludable from the basic TRICARE program by virtue of

1. Not being medically necessary
2. Not provided at an appropriate level
3. Or other reason relative to reasonableness, necessity, or appropriateness

then the beneficiary will not be held liable for such services. Under certain circumstances, payment may be made for the excludable services as if the exclusion for such services did not apply. A PSPR does not apply if the non-network participating provider or beneficiary had prior knowledge that the services were excludable.

A PSPR also does not apply to services provided by a network provider. Network providers may never bill beneficiaries for services denied for medical necessity or appropriateness. This requirement does not apply to TRICARE network pharmacies.

If a PSPR request is denied, then the TRICARE beneficiary can be held financially liable if one of the following situations applies:

• Both the non-network participating provider and the beneficiary knew the services were excluded
• The beneficiary did not notify the non-network participating provider about having TRICARE coverage
• The beneficiary knew the services were excluded but the non-network participating provider did not

Supporting documentation and the PSPR request and related information may be submitted to:

TRICARE West Region
Correspondence Department
P.O. Box 7065
Camden, SC 29021-7065

Claims Processing and Billing Information

West Region Claims Processor

PGBA is UnitedHealthcare's contractor for claims processing in the TRICARE West Region. For claims processing information, visit UHCMilitaryWest.com > Providers > Claims.

To contact PGBA about claims for beneficiaries eligible for both Medicare and TRICARE, see the explanation about filing claims for these beneficiaries later in this section.

Note: UnitedHealthcare does not administer the contract for TFL. You will need to contact the division of PGBA that administers this contract for TFL claims information. For more information, see Claims for Beneficiaries Using Medicare and TRICARE later in this section.

You may check the status of non-TFL claims by registering for the secure area of UHCMilitaryWest.com.

Claims Forms

Form 1500

The Form 1500 is used by physicians and other providers to bill government and commercial health plans.

Please contact the PGBA Electronic Data Interchange (EDI) Help Desk at 800-325-5920 to obtain additional information on submitting claims electronically. Providers are strongly encouraged to file claims electronically.
UB-04

The UB-04 form (or the 837 Institutional Transaction Set) is used by hospitals and other institutional providers to bill government and commercial health plans.

Note: The signature of non-network providers, or an acceptable facsimile, is required on all non-network claims in accordance with the TRICARE Operations Manual, Chapter 8, Section 4 at manuals.tricare.osd.mil. If a non-network claim does not contain an acceptable signature, the claim will be returned. Because the provider’s signature block Form Locator (FL) was eliminated from the UB-04, the National Uniform Billing Committee has designated FL 80 (Remarks), as the location for the non-network provider signature if signature-on-file requirements do not apply to the claim.

Claims Processing Standards and Guidelines

Filing Claims: Electronic Data Interchange (EDI)
PGBA staff members are skilled in working with a variety of provider specialties, billing services, and software vendors. Choosing one of their EDI options assures you receive assistance throughout the claims-filing process. The EDI edit systems are designed to minimize data entry errors before claims are passed to the PGBA processing system. Providers are strongly encouraged to file electronically.

EDI Software Option
You may choose an EDI software program from a vendor, clearinghouse, or billing service whose software already has been approved for TRICARE electronic claims submission. PGBA’s website, myTRICARE.com, provides all of the information you need to make an informed vendor or clearinghouse selection.

EDI Companion Guides
The associated EDI companion guides are available at myTRICARE.com including:

- 835 Electronic Remittance Advice Transaction
- 837 Claims Submission

HIPAA requires all health insurance payers in the United States to comply with the EDI standards for health care as established by the secretary of the U.S. Department of Health and Human Services. The ANSI X12N 837 implementation guides have been established as the standard for compliance for claims transactions.

UnitedHealthcare’s guides serve only as companion documents to the HIPAA ANSI X12N 837 Professional, Institutional, and Dental implementation guides. The information describes specific requirements to be used for processing data in the TRICARE processing system of PGBA.

When submitting claims, use the proper number of units for each line. For example, one visit is one unit. Behavioral health care providers must code each service on a separate line.

PGBA Electronic Data Interchange Contact Information
For information about filing claims electronically, you may contact PGBA by phone, email, or at their website:

<table>
<thead>
<tr>
<th>Phone</th>
<th>800-325-5920, Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:edi.tricare@pgba.com">edi.tricare@pgba.com</a></td>
</tr>
<tr>
<td>website</td>
<td>myTRICARE.com</td>
</tr>
</tbody>
</table>

Filing Paper Claims
If you are unable to submit claims electronically, please call 877-988-9378 or mail to:

PGBA West Region Claims
P.O. BOX 7064
Camden, SC 29021

Electronic Funds Transfer (EFT)
UnitedHealthcare offers EFT to network TRICARE West Region providers. To be eligible for EFT, network providers must accept Electronic Remittance Advise (ERAs) and agree to discontinue paper remittance advices.
Claims Processing Timelines
UnitedHealthcare and PGBA are committed to processing 98 percent of all clean claims (i.e., claims received with all necessary information and documentation) in 30 days. TRICARE claims-filing guidelines are similar to, but not necessarily the same as, Medicare’s. You should not submit referrals, authorizations, or medical records with the claim. UnitedHealthcare’s referral and authorization system will link the claims to referrals and authorizations that have been entered by providers on UnitedHealthcare’s secure website or by UnitedHealthcare staff. See the Health Care Management and Administration section for guidelines for referrals and authorizations.

Allow at least 30 days to receive payment or a provider remittance advice before resubmitting claims, as PGBA has 30 days from the date of receipt to process the claim. If you have registered for the secure area of UHCMilitaryWest.com, you may check claims status online. Registered users have several search options to easily find claims associated with their office(s). The search criteria include:

- Search by process date
- Search by claim number
- Search by patient account number
- Search by check number
- Search by individual provider

UnitedHealthcare will also respond to HIPAA-compliant Transaction 276/277.

Tracer Claims
Please avoid submitting tracer (second submission) claims. Use the secure area of UHCMilitaryWest.com to verify claims status or call 877-988-9378 (Claims Option for Claim Status). All claims submitted are acknowledged either with a payment, a provider remittance advice, or, in rare instances, returned with a specific request for additional information. In no case is a claim received and not acknowledged.

You may check claims status in the secure area of UHCMilitaryWest.com regardless of how the claim was submitted. Please refer to “Claims Processing Timelines” above in this section for additional information.

Interest Charges
You cannot bill penalties or interest charges to a beneficiary if TRICARE fails to make timely payment on a bill. TRICARE pays interest on claims that are processed more than 30 days after receipt.

HIPAA National Provider Identifier Compliance
All covered entities must use their NPIs on HIPAA standard electronic transactions in accordance with the appropriate HIPAA Implementation Guide. When filing claims with NPIs, billing NPIs are always required and rendering provider NPIs, when applicable, are also required.

Per the Implementation Guide, providers treating TRICARE beneficiaries as a result of referrals should also obtain the referring provider’s NPI, and include it on each transaction (if available). See the Important Provider Information section of this Handbook for additional details on HIPAA NPI compliance.

Unlisted Codes and Required Information
Some procedures may not be found in any level of the Healthcare Common Procedure Coding System (HCPCS). Typically, these are services that are rarely provided, or are unusual, variable, or unlisted procedures. In order for UnitedHealthcare to make an appropriate benefit determination, prior authorization for all unlisted codes is required.

In accordance with TRICARE requirements as well as industry standards, UnitedHealthcare requires additional information if unlisted codes, or not otherwise categorized (NOC) codes, are billed on a claim.

Figure 9.1 includes examples of Current Procedural Terminology (CPT®) codes, text description required, and documentation required. If a text note or documentation is required, UnitedHealthcare prefers that the text is entered on the documentation with a paper claim.

Note: Prior authorization is required for all unlisted codes.
### Unlisted Codes and Required Information

<table>
<thead>
<tr>
<th>Category of Unlisted Procedures</th>
<th>CPT Code Examples</th>
<th>Required Text, Documentation, Both, or Either</th>
<th>Text Description Required</th>
<th>Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>01999</td>
<td>Documentation</td>
<td>Surgeon's operative report</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>15999, 17999</td>
<td>Documentation</td>
<td>Surgeon's operative report</td>
<td></td>
</tr>
<tr>
<td>Procedure</td>
<td>36299, 38999</td>
<td>Either</td>
<td>Detailed description of the approved procedure</td>
<td>Procedure report</td>
</tr>
<tr>
<td>Radiology</td>
<td>76498, 76499</td>
<td>Either</td>
<td>Detailed description of the approved radiology procedure</td>
<td>Radiology report</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>77799, 78299</td>
<td>Documentation</td>
<td>Report signed by the physician indicating what services were performed</td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>87899, 88199</td>
<td>Documentation</td>
<td>Laboratory report</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>88399, 89240</td>
<td>Documentation</td>
<td>Pathology report pointing out the specific test used</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>J3490, J7199, C9399</td>
<td>Text</td>
<td>Drug name, unit of measure (mg, ml, or units), drug quantity, and National Drug Code if applicable</td>
<td></td>
</tr>
<tr>
<td>Evaluation and Management</td>
<td>99429, 99499</td>
<td>Text</td>
<td>Detailed description of the approved office service performed</td>
<td></td>
</tr>
<tr>
<td>Home Services</td>
<td>99600</td>
<td>Text</td>
<td>Detailed description of the approved services</td>
<td></td>
</tr>
<tr>
<td>Supplies/Durable Medical Equipment</td>
<td>L8699, E1399</td>
<td>Documentation</td>
<td>Supplier’s invoice</td>
<td></td>
</tr>
<tr>
<td>Enteral/Parenterals</td>
<td>B9998, B9999</td>
<td>Documentation</td>
<td>Supplier’s invoice</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>A0999</td>
<td>Text</td>
<td>Detailed description of services</td>
<td></td>
</tr>
</tbody>
</table>

#### Timely Filing

Network providers, by virtue of their contracts with UnitedHealthcare, should file all claims within 30 days. TRICARE requires that all claims be submitted to UnitedHealthcare no later than one year after the date the services were provided or one year from the date of discharge for an inpatient admission for facility charges billed by the facility. Professional services billed by the facility must be submitted within one year from the date of service or one year from the date of discharge for an inpatient admission.

A request for an exception to the claims filing deadline may be submitted by participating providers who are registered users of UHCMilitaryWest.com for consideration on a case-by-case basis. Appropriate attachments, a letter and copy of the claim may be submitted to:

TRICARE West Region  
Correspondence Department  
P.O. Box 7065  
Camden, SC 29021 -7065  

UnitedHealthcare reviews and gives individual consideration to each case.

After the proper claim has been submitted and an exception to the claims filing deadline granted, UnitedHealthcare considers only those services or supplies received during the six year period immediately preceding the receipt of the request.

#### Returning Incorrect Payments

If you receive an overpayment for a claim for TRICARE Prime, TPR, TPRADFM, TRICARE Standard and TRICARE Extra, TRS, TRR, or TYA beneficiaries, return it to PGBA. Overpayments for TFL claims also must be returned to PGBA, but to a different address, as noted below.

To accurately credit the refund to the correct claim when returning payments, include a copy of the provider remittance advice or ERA. If one of these documents is not available, include the TRICARE claim number, the last four digits of the sponsor’s SSN or DBN, beneficiary’s name, refund calculation, and any other pertinent information.
Return duplicate payments or overpayments (except TFL) to:
   TRICARE West Region Refunds
   P.O. Box 100268
   Columbia, SC 29202

Return TFL duplicate payments or overpayments to:
   Wisconsin Physicians Service
   ATTN: Refunds
   P.O. Box 7928
   Madison, WI 53707-7928

**West Region Recoupments**

When UnitedHealthcare, PGBA, or DHA identifies an overpayment, recoupment is set up in accordance with the *TRICARE Operations Manual*, Chapter 10, Section 3 and 4 at manuals.tricare.osd.mil.

An initial letter and a 30-day follow-up letter are mailed to the billing address of the group or facility. If the overpayment is returned by the provider in accordance with *Returning Incorrect Payments* section above, the recoupment case is closed. To accurately credit the recoupment to the correct case, include a copy of the original recoupment letter with the remittance.

If there is an overpayment balance remaining, UnitedHealthcare will offset it against current claims after 60 days with the exception of Out Patient Prospective Payment System and Home Health Care claims which are automatic offsets. The claims system will search for unpaid claims under the provider’s 18-digit group or facility number. If there are claims to be paid, those claims will be offset against the recoupment. If there are no unpaid claims under the 18-digit number, and there are unpaid claims under the provider’s Tax Identification Number (TIN), the offset is made against claims at the TIN level.

**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. Modifiers may be used by the physician 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
- GT Modifier – Tele-mental health from a distant site providers should use GT modifier
- Q3014 – is the tele-mental health origination site billing code.

**Signature-on-File Requirements**

When a TRICARE beneficiary has signed a *Release of Information* statement, you should indicate “signature on file” in Box 12 of the *Form 1500*. A new signature is required every year for professional claims submitted on a *Form 1500* and for every admission for claims submitted on a UB-04.

If the beneficiary is under age 18, the parent or legal guardian should sign the claim. However, a beneficiary under age 18 may sign the claim form if the beneficiary is (or was) the spouse of an ADSM or retiree, or if the services are related to venereal disease, drug or alcohol abuse, or abortion.
In situations when a beneficiary is mentally incompetent or physically incapable, the person signing should either be the legal guardian or, in the absence of a legal guardian, a spouse or parent of the beneficiary. See the Important Provider Information section of this Handbook for more information about the release of patient information.

If the beneficiary is deceased, and you do not have a valid signature-on-file agreement, you must submit one of the following:

- A claim form signed by the legal representative of the estate.
- Documentation accompanying the claim form to show the person signing is the legally appointed representative.
- If no legal representative has been appointed, the parent, spouse, or next of kin may sign the claim form. The signer must provide a statement that no legal representative has been appointed. The statement should contain the date of the beneficiary's death and the signer's relationship to the beneficiary.
- In the event there is no spouse, parent, or guardian to sign the claim form, the claim must be signed by the surviving next of kin or a legally appointed representative (indicate relationship to beneficiary).
- When there is no spouse, parent, guardian, next of kin, or legal representative to sign the claim form for a deceased beneficiary, payment may be made to the provider in accordance with state law and UnitedHealthcare corporate policy.

Signatures from the following individuals are not acceptable as beneficiary signatures:

- A provider or an employee of an institution rendering care
- An employee of an entity submitting a claim on behalf of a beneficiary, unless such employee is the beneficiary’s parent, legal guardian, or spouse

Claims submitted for diagnostic tests, test interpretations, or other similar services do not require the beneficiary’s signature. When submitting these claims, you must indicate “patient not present” on the claim form.

TRICARE randomly reviews claims to confirm that signature-on-file requirements are being followed.

**Physician Attestation Requirements**

It is not necessary to submit a signed physician attestation form with each claim submitted for payment. However, any TRICARE institution submitting claims for an attending physician must have a signed and dated acknowledgement from the attending physician on file indicating that the physician has received the following notice:

“Notice to Physicians: TRICARE payment to hospitals is based in part on each beneficiary’s principal and secondary diagnoses and the major procedures performed on the beneficiary, as attested to by the beneficiary’s attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fines, imprisonment, or civil penalty under applicable federal laws.”

The physician should sign this acknowledgement at the time he or she is granted admitting privileges. The signed and dated acknowledgement remains in effect as long as the physician has admitting privileges at the institution.

**Note:** The facility may use the Medicare physician attestation form and modify it to cover both Medicare and TRICARE. Any existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital. The attestations may be audited or reviewed and the absence of an attestation may result in nonpayment/recoupment.

**Special Processing Instructions**

**Lab and Radiology Billing**

When submitting claims for laboratory or radiology services rendered in a hospital setting, inpatient or outpatient, and you are a professional provider, use modifier 26 to indicate that you are billing for the professional component only. The hospital will submit claims for the technical component.

When submitting claims for laboratory or radiology services rendered in an office setting and you are a professional provider, indicate whether or not you are billing for the global fee or only the professional component. Use modifier 26 to indicate you are billing for the professional component only if sending the sample to a laboratory. You should also check “yes” in Box 20 of the *Form 1500* or 837 transaction. This allows payment to the laboratory for the technical component. If you do not use a modifier and
do not indicate "yes" in Box 20 of the Form 1500, you will be paid the global fee. Should the laboratory subsequently bill for the technical component, that claim will be denied.

**Note:** Clinical labs billing for services for inpatient hospital patients must bill the facility, not TRICARE, for the lab tests. Repeated failure to follow this rule will cause the clinical lab to have all claims returned to them without processing.

**Venipuncture**
Venipuncture is denied or paid based on the setting in which it is provided. Denial or payment is also determined by whether or not the lab results are read by the provider of care. When submitting venipuncture claims, specify “yes” or “no” in Box 20 of the Form 1500 or 837 transaction to indicate if an outside laboratory was used. If the labs are drawn in a provider’s office, but read in an outside laboratory, TRICARE pays for the venipuncture.

**Allergy Testing and Treatment Claims**
Certain types of allergy tests are not covered under TRICARE. Prior to completing an allergy test, determine if the service is a covered benefit, if it requires a referral or an authorization, or if the service needs medical review.

When submitting claims for allergy testing and treatment, use the appropriate CPT code and indicate on the claim form the type and number of allergy tests performed. When filing claims for the administration of multiple allergy tests, group the total number of tests according to the most up-to-date CPT-4 code book definitions of relevant codes. In Column 24G (Days or Units) of the Form 1500 claim form, indicate the number of replacement antigen sets (not vials) being billed.

A limited number of replacement antigen sets are payable pending medical review and approval. Always bill with the appropriate CPT code, whether the replacement set consists of one vial or two or more vials.

**Global Maternity Claims**
Global maternity involves the billing process for maternity-related claims for a beneficiary. Once a beneficiary has been diagnosed as pregnant, all charges related to the pregnancy are grouped under one global maternity diagnosis code.

These diagnosis codes will be listed as the primary diagnosis when billing.

When beneficiaries are referred for specialty obstetric care, prior authorization must be obtained for both outpatient and inpatient services.

Maternal Serum Alpha Fetoprotein and Multiple Marker Screen Test are cost-shared separately (outside 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®.

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

**ClaimCheck**
The TRICARE West Region contract uses a version of the McKesson HbOC ClaimCheck® product to review non-Outpatient Prospective Payment System (non-OPPS) claims on a prepayment basis for unbundling.

ClaimCheck is an automated product that contains specific auditing logic designed to evaluate professional billing for CPT coding appropriateness and to eliminate overpayment.

The current web-based version (ClaimCheck 8.5.47) has the ability to read up to four modifiers on each claim line, as well as the ability to handle HCPCS codes the same way as CPT codes.
**ClaimCheck Edits**

You should follow CPT coding guidelines to prevent claim denials due to ClaimCheck editing. Any edits made by ClaimCheck will be explained by a message code on the provider remittance advice. ClaimCheck includes the following edit categories:

- Age Conflicts
- Alternate Code Replacements
- Assistant Surgeon Requirements
- Billed Date(s) of Service
- Cosmetic Procedures
- Duplicate and Bilateral Procedures
- Gender Conflicts
- Incidental Procedure
- Modifier Auditing
- Mutually Exclusive Procedure
- Preoperative (pre-op) and Postoperative (post-op) Auditing Billed
- Procedure Unbundling
- Unlisted Procedures

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

**Electrocardiograms and Office Visit Billing**

When an electrocardiogram (ECG) is done in conjunction with an evaluation and management (E&M) visit and is billed separately, TRICARE does not pay this service separately since an E&M visit is determined by time and the ECG review is a part of that time. A “Procedure Unbundling” edit will appear on the provider remittance advice. If additional time was taken to perform the ECG, a higher-level code should be used for the office visit.

**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. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedure, where the physician should be submitting only one procedure code. Example: Procedure 58260 (vaginal hysterectomy) and procedure 58150 (total abdominal hysterectomy) are considered to be mutually exclusive.

**ClaimCheck Review Requests**

ClaimCheck findings are “allowable charge determinations” and, as such, are not appealable. However, participating providers do have recourse through medical review. Issues appropriate for medical review include:

- Requests for verification that the edit was correctly applied to the claim
- Requests for an explanation of ClaimCheck auditing logic
- Situations in which you submit additional documentation substantiating that unusual circumstances existed

Requests for review of ClaimCheck edits must be received within 90 days of the date of the remittance advice and are resolved within 45 days of receipt. Participating providers who are interested in a medical review should request consideration on a case-by-case basis. Appropriate attachments with supporting documentation, a letter and copy of the claim may be submitted to:

TRICARE West Region  
Correspondence Department  
P.O. Box 7065  
Camden, SC 29021-7065

Following medical review, UnitedHealthcare may override the ClaimCheck edit and allow additional amounts to be paid.

You are not permitted to bill TRICARE beneficiaries for amounts considered unbundled or incidental by ClaimCheck.
TRICARE Claim Disputes

In the event you disagree with reimbursement rates, you may request a claim review (allowable charge review). A claim review differs from an appeal which is only for charges denied as “not covered” or not “medically necessary.”

The following subsections detail the appropriate types of review requests, time frames for submitting requests, contact information, and the information to include with requests. By following the rules and timelines for requesting reviews, you can help promptly resolve your request.

Claims Adjustments and Allowable Charge Reviews

An allowable charge review can be requested by a provider or beneficiary if either party disagrees with the reimbursement allowed on a claim. This includes a review of unlisted procedures.

The following issues are considered reviewable:

- Allowable charge disputes
- Charges denied as “included in a paid service”
- Wrong code
- Eligibility denials
- Cost-share and deductible inquiries/disputes
- Claims denied as “provider not authorized”
- Claims denied as not medically necessary
- OHI denials/issues
- Third-party liability denials/issues
- Penalties for a non-authorized service
- Claims processed as Point-of-Service
- Claims denied as “requested information was not received”
- Coding issues

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

- Letter with the reason for requesting the claim review
- A copy of the claim and the TRICARE EOB or TRICARE summary payment voucher/remit
- Supporting medical records and any new information that was not originally submitted with the claim

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

Your request and appropriate attachments should be mailed to:

TRICARE West Region
Correspondence Department
P.O. Box 7065
Camden, SC 29021-7065

For information about filing an appeal, UHCMilitaryWest.com > Beneficiaries > Claims > Appeals and Grievances.

Outpatient Institutional Claims Processing

UnitedHealthcare uses the Centers for Medicare and Medicaid Services (CMS) guidelines for reimbursement and claims processing, although reimbursement will be made according to the TRICARE-allowable charge. Hospitals, birthing centers, and ambulatory surgery centers (ASCs) reporting outpatient services on a UB-04, 837I or online submittal should indicate the HCPCS codes that best describe the services rendered in FL 44 or the electronic equivalent, as applicable. HCPCS Level I codes, Level
PII codes, and revenue codes are required for all services except supplies and some drugs. HCPCS Level II codes are required for drugs administered by injection or infusion, but not for other prescription drugs.

Some surgical procedures may not be found in any level of HCPCS. Typically, these are services that are rarely provided, or are unusual, variable, or unlisted procedures. In order for UnitedHealthcare to make an appropriate benefit determination, all care billed with unlisted codes must include descriptions of the items and pricing, if available, and have prior authorization. Claims with unlisted codes must contain an item number or a National Drug Code, if appropriate. If it is determined that an adequately descriptive code is contained in HCPCS, PGBA will return the claim to the provider for the appropriate HCPCS/CPT code. If, after review, the determination is that no existing code sufficiently describes the procedure, PGBA will process the claim according to the documentation submitted and reimburse the claim according to the standard reimbursement rates as listed on myTRICARE.com > Billing Information, and on tricare.mil/DHA > Rates and Reimbursements. HCPCS includes two levels of codes and modifiers:

- Level I: the numeric CPT codes used by the American Medical Association
- Level II: alphanumeric codes for physician and other provider services not included in CPT (e.g., ambulance, DME, orthotics, and prosthetics)

All provider specialties and types of institutions (except those listed in Figure 9.2 below), must report HCPCS codes on institutional claims. Outpatient hospital services must be billed on a UB-04; they cannot be billed on a Form 1500, 837P or website using the SG modifier.

### Institutional Reporting Code Types

<table>
<thead>
<tr>
<th>Institution</th>
<th>Code Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian Science Sanatoria</td>
<td>Revenue Codes</td>
</tr>
<tr>
<td>Dentists and dental services</td>
<td>American Dental Association® Current Dental Terminology Codes</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>National Drug Codes</td>
</tr>
<tr>
<td>Residential treatment centers</td>
<td>Revenue Codes</td>
</tr>
<tr>
<td>Skilled nursing facilities</td>
<td>Revenue Codes</td>
</tr>
</tbody>
</table>

For related information, see “Outpatient Prospective Payment System” in the TRICARE Reimbursement Methodologies section of this Handbook.

### Proper Treatment Room Billing

Under the TRICARE OPPS reimbursement methodology, payment of 0510 and 0760 series revenue codes are based on the HCPCS codes billed on the claim.

#### Revenue Code 076X

Determining when to use revenue code 076X (treatment or observation room) to indicate use of a treatment room may be confusing, and improper coding may lead to inappropriate billing.

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:

- An 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 076X should not be used when the claim is submitted with a type of bill 083X and ASC procedure codes. ASC facility services are reimbursed under the ASC grouper reimbursement or OPPS.

#### Revenue Code Series 051X

Figure 9.3 lists revenue codes that are reimbursed for facilities billing with revenue code series 051X.
Revenue Code Series 051X

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>510</td>
<td>Clinic, general class</td>
</tr>
<tr>
<td>511</td>
<td>Clinic, chronic pain</td>
</tr>
<tr>
<td>512</td>
<td>Clinic, dental (not payable for TRICARE)</td>
</tr>
<tr>
<td>513</td>
<td>Clinic, psychiatric</td>
</tr>
<tr>
<td>514</td>
<td>Clinic, OBGYN</td>
</tr>
<tr>
<td>515</td>
<td>Clinic, pediatric</td>
</tr>
<tr>
<td>516</td>
<td>Reserved</td>
</tr>
<tr>
<td>517</td>
<td>Clinic, family practice</td>
</tr>
<tr>
<td>518</td>
<td>Reserved</td>
</tr>
<tr>
<td>519</td>
<td>Clinic, other</td>
</tr>
</tbody>
</table>

Billing with ICD-9 V Codes or ICD-10 Z Codes

It is very important to use the proper V codes (when applicable) for claims reimbursement. A V code may designate a primary diagnosis for an outpatient claim that explains the reason for a patient’s visit to your office. V codes should be used for preventive or other screening claims; all other claims should be billed with the standard numeric ICD-9 diagnosis codes. **Note:** TRICARE policy defines V-code diagnoses as "conditions not attributable to a mental disorder." Therefore, V code diagnoses for TRICARE behavioral health care services are not covered. V codes also should not be used for routine physical examinations, although a V code may be billed in conjunction with other valid codes. For dates of service after the transition to ICD-10, use the relevant Z codes.

Choose the Correct ICD-9 V Code or ICD-10 Z Code

For dates of service prior to the transition to ICD-10, use the correct V-code diagnosis to indicate the reason for the visit. For dates of service on or after the transition to ICD-10, use the correct Z code (see Figure 9.4). The V or Z code must match the CPT/HCPCS code to indicate the procedure that you are performing as it correlates to the V code or Z code diagnosis. If you bill vague diagnosis codes, they will not be paid.

How to Bill with V Codes (for Dates of Service Prior to the Transition to ICD-10)

V codes correspond with descriptive, generic, preventive, ancillary, or required medical services and should be billed accordingly.

*Descriptive V Codes*

For V codes that provide descriptive information as the reason for the patient visit, you may designate that description as the primary diagnosis. An example of a descriptive V code includes a routine infant or child health visit, which is designated as V20.2.

*Generic V Codes*

For generic non-payable services, such as lab, radiology, or pre-op, a generic V code should not be used as a primary diagnosis. Rather, the underlying medical condition should be listed as the primary diagnosis for these ancillary services.

*Preventive V Codes*

For preventive services, a V code that describes a personal or family history of a medical condition is sufficient as a primary diagnosis without the need for additional diagnostic information. Examples are a mammogram, a Pap smear, or a fecal occult blood screening.

Figure 9.4 on the following page lists clinical preventive services and the corresponding V codes.

How to Bill with Z Codes (for Dates of Service on or after the Transition to ICD-10)

Z codes correspond with descriptive, generic, preventive, ancillary, or required medical services and should be billed accordingly.

*Descriptive Z Codes*

For Z codes that provide descriptive information as the reason for the patient visit, you may designate that description as the primary diagnosis. An example of a descriptive Z code includes a routine infant or child health visit, which is designated as Z00.121, Z00.129, Z00.2, Z00.70, or Z00.71.
**Generic Z Codes**

For generic non-payable services, such as lab, radiology, or pre-op, a generic Z code should not be used as a primary diagnosis. Rather, the underlying medical condition should be listed as the primary diagnosis for these ancillary services.

**Preventive Z Codes**

For preventive services, a Z code that describes a personal or family history of a medical condition is sufficient as a primary diagnosis without the need for additional diagnostic information. Examples are a mammogram, a Pap smear, or a fecal occult blood screening. Figure 9.4 lists clinical preventive services and the corresponding Z codes.

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### Clinical Preventive Services ICD-9 V Codes and ICD-10 Z Codes

<table>
<thead>
<tr>
<th>Preventive Service</th>
<th>Proper V Codes (before transition to ICD-10)</th>
<th>Proper Z Codes (on or after transition to ICD-10)</th>
<th>Care Intervals and Notes</th>
</tr>
</thead>
</table>
| Colonoscopy        | V76.51                                      | Z12.11 Z80.0 (if applicable)                  | **Individuals at average risk for colon cancer:**  
  • Colonoscopy covered once every 10 years beginning at age 50. |
|                    |                                            |                                               | **Individuals at increased risk for colon cancer:**  
  • Colonoscopy once every five years for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp before age 60, or in two or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at either 40 or 10 years younger than the earliest affected relative, whichever is earlier.  
  • Colonoscopy once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second-degree relatives. |
|                    |                                            |                                               | **Individuals at high risk for colon cancer:**  
  • Colonoscopy once every one to two years for individuals with a genetic or clinical diagnosis of hereditary non-polyposis colorectal cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20–25 or 10 years younger than the earliest age of diagnosis, whichever is earlier.  
  • For individuals diagnosed with inflammatory bowel disease, chronic ulcerative colitis, or Crohn’s disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10–12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.  
  • There are no copayments or cost-shares required for TRICARE Prime or TRICARE Standard and TRICARE Extra beneficiaries. |
| Mammograms         | V76.10 V76.11 V76.12                       | Z12.31                                       | **Note:** Computed tomographic colonography (CTC) is covered as a colorectal cancer screening only when an optical colonoscopy is medically contraindicated or cannot be completed due to a known colonic lesion or structural abnormality, or when other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is not covered as a colorectal cancer screening for any other indication or reason.  
  • Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15 percent or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:  
    - History of breast cancer, Ductal Carcinoma In Situ, Lobular Carcinoma In Situ, Atypical Ductal Hyperplasia, or Atypical Lobular Hyperplasia  
    - Extremely dense breasts when viewed by mammogram  
    - Known BRCA1 or BRCA2 gene mutation  
    - First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves  
    - Radiation therapy to the chest between ages 10 and 30  
    - History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes  
  • There are no copayments or cost-shares for TRICARE Prime or TRICARE Standard and TRICARE Extra beneficiaries. |

**Note:** The mammogram and add-on codes must be submitted on the same claim if performed on the same date of service.
<table>
<thead>
<tr>
<th>Preventive Service</th>
<th>Proper V Codes (before transition to ICD-10)</th>
<th>Proper Z Codes (on or after transition to ICD-10)</th>
<th>Care Intervals and Notes</th>
</tr>
</thead>
</table>
| Optometry (eye examinations) | V72.0                                        | Z01.00, Z01.01                                    | **Active duty service members (ADSMs):**  
  - TRICARE Prime ADSMs must receive all vision care at a MTF unless specifically referred to a network provider (or non-network provider if a network provider is not available).  
  - TRICARE Prime Remote ADSMs may obtain comprehensive eye examinations from network providers as needed to maintain fitness-for-duty status without authorization.  

**Active duty family members (ADFM):**  
- One routine eye examination to check for vision and diseases within a 12 month period, regardless of TRICARE program option.  
- Medically necessary care for injuries to the eye is covered.  

**Retired service members and their dependents:**  
- (includes all beneficiaries other than ADSMs and ADFMs)  
- If enrolled in TRICARE Prime, one routine eye examination to check for vision and diseases every two years (except for diabetic patients, see “Diabetic patients” later in this figure).  
- If using TRICARE Standard and TRICARE Extra or TRICARE For Life, no coverage (except for well-child benefit and diabetic patients, see “Well-child benefit” and “Diabetic patients” later in this figure).  
- Medically necessary care for injuries to the eye is covered.  

**Well-child benefit:**  
- For all TRICARE-eligible infants and children up to age 6:  
- Infants may receive one eye and vision screening during routine examinations at birth and at approximately six months under the well-child benefit. Use V20.2, Z00.121, or Z00.129 for eye examinations under the well-child benefit.  
- Children may receive two pediatric routine eye exams between ages 3 and 6 under the well-child benefit (use V20.2, Z00.121, or Z00.129).  

**Diabetic patients:**  
- Diabetic patients at any age are allowed one routine eye examination each calendar year.  

Note: For TRICARE Prime enrollees, a primary care manager (PCM) or UnitedHealthcare referral is not needed, but TRICARE Prime beneficiaries must see an MTF or network optometrist or ophthalmologist. The V or Z code can be used for the annual examination; however, if a medical condition is identified, use medical diagnosis CurrentProceduralTerminology (CPT®) codes.  

<table>
<thead>
<tr>
<th>Preventive Service</th>
<th>Proper V Codes (before transition to ICD-10)</th>
<th>Proper Z Codes (on or after transition to ICD-10)</th>
<th>Care Intervals and Notes</th>
</tr>
</thead>
</table>
| Pap smear                  | V72.31, V72.32, V76.2, V76.47               | Z01.411, Z01.419, Z12.4                          | Annually for women over age 18 (younger if sexually active) until three consecutive satisfactory normal annual examinations. Frequency may then be less often at the discretion of the patient and clinician, but not less frequently than every three years. No PCM or UnitedHealthcare referral or copayment is required for TRICARE Prime beneficiaries who use network providers.  
| Procto-sigmoidoscopy/sigmoidoscopy | V76.51                                     | Z12.11, Z80.0 (if applicable)                    | Individuals at average risk for colon cancer:  
  - Proctosigmoidoscopy/sigmoidoscopy once every three to five years beginning at age 50.  
  - Individuals at increased risk for colon cancer:  
  - Proctosigmoidoscopy/sigmoidoscopy once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives.  
  - Individuals at high risk for colon cancer:  
  - Annual flexible sigmoidoscopy, beginning at age 10–12, for individuals with known or suspected familial adenomatous polyposis.  

<table>
<thead>
<tr>
<th>Preventive Service</th>
<th>Proper V Codes (before transition to ICD-10)</th>
<th>Proper Z Codes (on or after transition to ICD-10)</th>
<th>Care Intervals and Notes</th>
</tr>
</thead>
</table>
| Regular immunizations      | V20.2 (includes well-child check)           | Z00.121, Z00.129, Z00.2, Z00.70, Z00.71, Z23      | Immunizations should be administered at age-appropriate doses as suggested by the current schedule of recommended vaccines for use in the United States by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices at CDC.gov.  

Note: Immunizations recommended specifically for travel outside the United States are not covered, except for immunizations required for ADFMs whose sponsors have permanent change-of-station orders to overseas locations, which are covered as outpatient office visits.  

Note: For TRICARE Prime enrollees, a primary care manager (PCM) or UnitedHealthcare referral is not needed, but TRICARE Prime beneficiaries must see an MTF or network optometrist or ophthalmologist. The V or Z code can be used for the annual examination; however, if a medical condition is identified, use medical diagnosis CurrentProceduralTerminology (CPT®) codes.
School physicals (Note: Sports-related physical examinations are not a covered benefit.)

- V70.3 Z02.0

- TRICARE-eligible dependents who are at least age 5 and less than age 12 may get physical examinations that are required by a school in connection with the enrollment of the dependent as a student in that school. This benefit does not include physical examinations that may be required by the school to participate in school sports, as they are not considered benefits. Physicals for children age 12 and older are authorized only if the physical is required.

- TRICARE Prime beneficiaries do not have copayments when using network providers.

- TRICARE Standard and TRICARE Extra beneficiaries will pay the applicable cost-share and deductibles.

Well-child visits

- V20.2 Z00.121 Z00.129 Z00.2 Z00.70 Z00.71

- Includes routine newborn care, comprehensive health promotion (birth to age 6) and disease-prevention examinations, vision and hearing screenings, height/weight/head circumference, routine immunizations (according to CDC guidelines), and developmental/behavioral appraisals (according to American Academy of Pediatrics®).

- Copayments or cost-shares are not required of TRICARE Prime or TRICARE Standard and TRICARE Extra beneficiaries.

1. Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

2. Infant screening includes visual acuity, ocular alignment, red reflex, and external examination.

3. Pediatric routine eye examination includes amblyopia and strabismus examination.

Processing Claims for Out-of-Region Care

If you have treated a TRICARE patient from another TRICARE region, submit the claims to the TRICARE region where the beneficiary resides and/or is enrolled in TRICARE Prime for faster payment. TRICARE pays based on where the beneficiary resides or is enrolled (except when care is received overseas), whereas Medicare pays based on where the services are rendered.

For example, if a provider in the West Region cares for a TRICARE Prime, TPR, or TPRADFM beneficiary from a state located in the North Region or the South Region, the provider should submit the claim to the responsible contractor for that region to expedite payment. PGBA can forward the claim to the appropriate region, but it may result in a delay in payment. If the claim is filed electronically to PGBA, the claim will be electronically forwarded to the appropriate region.

North Region 877-TRICARE/877-874-2273

The North Region includes Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Iowa (Rock Island Arsenal area only), Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri (St. Louis area only), New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee (Fort Campbell area only), Vermont, Virginia, West Virginia, and Wisconsin.

Paper claims should be sent to:

Health Net Federal Services, LLC

c/o PGBA Claims

P.O. Box 870140

Surfside Beach, SC 29587-9740

South Region 800-403-3950

The South Region includes Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee (excluding the Ft. Campbell area), and Texas (excluding the El Paso area).

Paper claims should be sent to:

PGBA South Region Claims Department

P.O. Box 7031

Camden, SC 29020-7031
Claims for Beneficiaries Assigned to US Family Health Plan Designated Providers

Designated providers are facilities specifically contracted with the DoD to provide care to beneficiaries enrolled in the USFHP. The USFHP is offered in six geographic regions in the United States. Although it provides the TRICARE Prime benefit, the USFHP is a separately funded program different from the TRICARE program administered by UnitedHealthcare. The designated provider is at full risk for all medical care for a USFHP enrollee, including pharmacy services, primary care, and specialty care.

If you provide care to a USFHP enrollee outside the network or in an emergency situation, claims must be filed with the appropriate designated provider at one of the addresses listed in Figure 9.5. Do not file USFHP claims with UnitedHealthcare. For more information about the USFHP, visit USFHP.com.

USFHP Designated Providers

<table>
<thead>
<tr>
<th>Martin’s Point Health Care</th>
<th>Johns Hopkins Medical Services Corporation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTN: Claims</td>
<td>U.S. Family Health Plan/TRICARE</td>
</tr>
<tr>
<td>P.O. Box 11410</td>
<td>ATTN: Claims Department</td>
</tr>
<tr>
<td>Portland, ME 04104-7410</td>
<td>P.O. Box 33</td>
</tr>
<tr>
<td></td>
<td>Glen Burnie, MD 21060</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Brighton Marine Health Center</th>
<th>CHRISTUS Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTN: USFHP Claims P.O. Box 9195</td>
<td>U.S. Family Health Plan ATTN: Claims</td>
</tr>
<tr>
<td>Watertown, MA 02471-9900</td>
<td>P.O. Box 924708</td>
</tr>
<tr>
<td></td>
<td>Houston, TX 77292-4708</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>St. Vincent Catholic Medical Centers of New York</th>
<th>Pacific Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Family Health Plan at SVCMC ATTN: Claims</td>
<td>1200 12th Avenue South, Quarters eight &amp; 9</td>
</tr>
<tr>
<td>P.O. Box 830745</td>
<td>Seattle, WA 98144-2790</td>
</tr>
<tr>
<td>Birmingham, AL 35283-0745</td>
<td></td>
</tr>
</tbody>
</table>

TRICARE Overseas/Foreign Claims

International SOS Assistance, Inc. (International SOS) administers the TRICARE program overseas and handles claims processing for all overseas claims, regardless of where the beneficiary is enrolled. If filing a claim for an ADSM who is enrolled in a TRICARE Overseas Program (TOP) option (TOP Prime or TOP Prime Remote), submit it to the address listed in Figure 9.6. If filing a claim for a non-ADSM in a TOP option, submit it to one of the addresses listed in Figure 9.7.

Note: This includes TFL claims for medical care received outside the United States and its territories.

TRICARE Overseas Claims Contact Information—ADSMs

<table>
<thead>
<tr>
<th>All overseas areas</th>
<th>TRICARE Overseas Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 7968</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707-7968</td>
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</tbody>
</table>

TRICARE Overseas Claims Contact Information—Non-ADSMs

<table>
<thead>
<tr>
<th>TRICARE Eurasia-Africa (Africa, Europe, and the Middle East)</th>
<th>TRICARE Overseas Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 8976</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53708-8976</td>
</tr>
<tr>
<td></td>
<td>877-678-1207</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRICARE Pacific Latin America and Canada (Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands)</th>
<th>TRICARE Overseas Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 7985</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707-7985</td>
</tr>
<tr>
<td></td>
<td>877-451-8659</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRICARE Pacific (Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries)</th>
<th>TRICARE Overseas Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 7985</td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707-7985</td>
</tr>
<tr>
<td></td>
<td>Singapore: 877-678-1208</td>
</tr>
<tr>
<td></td>
<td>Sydney: 877-678-1209</td>
</tr>
</tbody>
</table>
Overseas claims for National Guard and Reserve members on orders of 30 days or less should also be sent to International SOS. 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. Fax the forms and attachments to 608-301-2251.

For more information on filing claims for TOP beneficiaries, visit tricare-overseas.com > Provider > TOP Claims Submission Guidelines.

**Claims for Beneficiaries Using Medicare and TRICARE**

WPS is the claims processor for all TFL claims.

**Note:** While WPS is the claims processor for the West Region, claims are filed differently for beneficiaries eligible for both TRICARE and Medicare. UnitedHealthcare cannot provide claims information for these beneficiaries.

If you currently submit claims to Medicare on your patients’ behalf, you will not need to submit claims to WPS.

WPS has signed agreements with each Medicare carrier allowing them to submit claims directly to WPS for TRICARE beneficiaries, regardless of age. Claims processed by Medicare are submitted electronically to WPS/TFL. Beneficiaries and providers will receive remittance advices from WPS/TFL once processing has been completed. If you do not participate in Medicare, or the services you perform are not Medicare benefits, you will need to submit paper claims to WPS/TFL.

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

When TRICARE is the primary payer, all TRICARE requirements apply. Refer to the **TRICARE Reimbursement Manual**, Chapter 4 on manuals.tricare.osd.mil for details.

Figure 9.8 contains important contact information for you or your patients regarding TRICARE and Medicare claims.

### TRICARE and Medicare Claims Contact Information

| **Claims submission (Note: Submit claims to Medicare first.)** | WPS TRICARE For Life  
P.O. Box 7890  
Madison, WI 53707-7890 |
|---|---|
| **Customer service** | WPS TRICARE For Life  
P.O. Box 7889  
Madison, WI 53707-7889 |
| **Online** | TRICARE4u.com |
| **Toll-free telephone** | 866-773-0404 |
| **Toll-free TDD** | 866-773-0405 |

### Claims for NATO Beneficiaries

TRICARE covers the North Atlantic Treaty Organization (NATO) foreign nations’ armed forces members who are stationed in the United States or are in the United States at the invitation of the U.S. Government. The benefits are the same as for American ADSMs, including no out-of-pocket expenses for care that is directed by the MTF.

Eligible family members of active duty members of NATO nations who are stationed in or passing through the United States in connection with their official duties are eligible for outpatient services under TRICARE Standard and TRICARE Extra. A copy of the family member’s identification card will have a Foreign Identification Number (issued by the DEERS) and indicate on the reverse “Outpatient Services Only.”

NATO family members do not need MTF referrals prior to receiving outpatient services from civilian providers. NATO family members follow the same prior authorization requirements as TRICARE Standard and TRICARE Extra beneficiaries. Like all TRICARE Standard and TRICARE Extra beneficiaries, NATO family members are responsible for TRICARE Standard and TRICARE Extra deductibles and cost-shares. To collect charges for services not covered by TRICARE, you must have the NATO beneficiary agree, in advance and in writing, to accept financial responsibility for any non-covered service. You may obtain a copy of the Waiver of Non-Covered Services form at UHCMilitaryWest.com > Providers > Find a Form > General.
NATO claims for ADSMs and ADFMs should be filed electronically the same way other TRICARE claims are submitted. If claims are submitted by mail, submit to:

TRICARE West Region
Claims Department
P.O. Box 7064
Camden, SC 29021-7064

TRICARE will not cover inpatient services for NATO beneficiaries. In order to be reimbursed for inpatient services, the NATO beneficiary should make the appropriate arrangements with the NATO nation embassy or consulate in advance.

Eligibility for NATO beneficiaries is maintained in DEERS and is available on the secure website at UHCMilitaryWest.com. Claims submission procedures are the same as for American ADFMs.

**Claims for CHAMPVA**

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is not a TRICARE program. For questions or general correspondence, please contact CHAMPVA by any of the means listed in Figure 9.9.

**CHAMPVA Contact Information**  
*Figure 9.9*

<table>
<thead>
<tr>
<th>Phone</th>
<th>800-733-8387</th>
</tr>
</thead>
</table>
| Mail    | VA Health Administration Center  
CHAMPVA  
P.O. Box 469063  
Denver, CO 80246-9063 |
| website | va.gov/purchasedcare/programs/providerinfo |
| Email   | Inquiry Routing & Information System, iris.custhelp.com/app/ask |

Claims for current treatment must be filed within 365 days of the date of service. Providers may file health care claims on behalf of their patients. If you wish to file a paper health care claim, CHAMPVA claim forms may be downloaded from the CHAMPVA website. To file a paper health care claim within the 1-year filing deadline, send the claim to:

VA Chief Business Office Purchased Care  
CHAMPVA Claims  
P.O. Box 469064  
Denver, CO 80246-9064

Written appeals may be requested if exceptional circumstances prevented you from filing a claim in a timely fashion. Send written appeals to:

VA Chief Business Office Purchased Care  
CHAMPVA  
ATTN: Appeals  
P.O. Box 460948  
Denver, CO 80246-0948

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

If your CHAMPVA claim is misdirected to PGBA, PGBA will forward CHAMPVA claims to the CHAMPVA VA Health Administration Center within 72 hours of identification as a CHAMPVA claim. A letter will be sent to the claimant informing him or her of the transfer. The letter includes instructions on how to submit future CHAMPVA claims and to direct any correspondence for CHAMPVA beneficiaries to the CHAMPVA VA Health Administration Center.

**Claims for CHCBP**

Humana Military Healthcare Services, Inc. is the contractor for CHCBP and has contracted with PGBA for processing non-overseas CHCBP claims. For questions and assistance regarding CHCBP claims, please call PGBA at 800-403-3950. UnitedHealthcare will not be able to answer any questions about CHCBP claims.
CHCBP beneficiaries may request that you file medical claims on their behalf. File CHCBP claims electronically at myTRICARE.com. File all paper claims at one of the addresses listed in Figure 9.10.

### CHCBP Claims Addresses

<table>
<thead>
<tr>
<th>CHCBP Behavioral Health Claims</th>
<th>All other CHCBP Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 7034</td>
<td>P.O. Box 7034</td>
</tr>
<tr>
<td>Camden, SC 29020-7034</td>
<td>Camden, SC 29020-7034</td>
</tr>
</tbody>
</table>

### Claims for ECHO

All TRICARE ECHO claims must have a valid written authorization. All claims for ECHO-authorized care (including ECHO Home Health Care) shall be billed on individual line items. Unauthorized ECHO claims will be denied.

ECHO claims will be reimbursed for the amount authorized to the fiscal year benefit limit. Each line item on an ECHO claim needs to 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](https://manuals.tricare.osd.mil) at manuals.tricare.osd.mil.

**Note:** Claims for the TRICARE Autism services use special procedure codes and require special certification. Please see the TRICARE Extended Care Health Option (ECHO) section and work with the beneficiary’s ECHO nurse.

### Claims for the SHCP

Claims for the SHCP are processed and paid through PGBA.

The same balance billing limitations applicable to TRICARE apply to the SHCP. For more information regarding balance billing, see the Important Provider Information section of this Handbook.

### Claims for TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult

For individuals covered under TRS, follow the applicable cost-shares, deductibles, and catastrophic caps for ADFMs using TRICARE Standard and TRICARE Extra. For additional information, visit tricare.mil/trs.

For individuals covered under TRR, follow the applicable cost-shares, deductibles, and catastrophic caps for TRICARE retirees using TRICARE Standard and TRICARE Extra. For additional information, visit tricare.mil/trr.

TYA Standard has the same cost-shares as TRICARE Standard and TRICARE Extra and contributes to individual and family deductibles and to the family’s catastrophic cap. Deductibles and cost-shares for TYA beneficiaries are based on their sponsor’s status. If the sponsor is an ADSM or TRS member, ADFM cost-shares apply. If the sponsor is a retiree or TRR member, retiree cost-shares apply. For additional information, visit tricare.mil/tya.

### TRICARE Network Providers

Claims must be filed electronically with PGBA on behalf of TRS, TRR and TYA members in the same manner as other TRICARE West Region claims.

### Non-Network TRICARE-Authorized Providers

Participation with TRICARE (e.g., accepting assignment, filing claims, accepting the TRICARE-allowable charge as payment in full) is encouraged, but not required.
If a non-network provider does not participate on a particular claim, members will file their own claims with TRICARE for reimbursement and then pay the non-network provider.

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.

The TRICARE-allowable charge schedules can be found at tricare.mil/cmac.

**TRICARE and Other Health Insurance (OHI)**

TRICARE is the last payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other programs or plans as identified by DHA.

TRICARE beneficiaries who have OHI are not required to obtain referrals or prior authorizations for covered services, except in the case of the ECHO services, ABA services, in-patient behavioral health, DME exceeding $150, and transplants, which continue to require prior authorization even when OHI coverage exists.

Prior authorization is required once TRICARE becomes primary as a result of exhaustion of benefit for Residential Treatment Centers (RTC) or excluded benefit for behavioral health services if it is a covered benefit under TRICARE. In the case of RTC, UnitedHealthcare should be contacted even when OHI is primary so we can assure that continuity is supported if the benefit is exhausted.

You are encouraged to ask the beneficiary about OHI so that benefits can be coordinated. Since OHI status can change at any time, it is important to obtain this information from the beneficiary on a routine basis, including family members of activated National Guard and Reserve members. If a beneficiary’s OHI status changes, make sure to update patient billing system records to avoid delays in claim payments. If you indicate that there is no OHI, but DEERS indicates otherwise, a signed or verbal notice from the beneficiary will be required to inactivate the OHI record. To update OHI information, beneficiaries may complete the **OHI Questionnaire** form available at UHCMilitaryWest.com > Beneficiary > Find a Form > Claims Forms.

### Submitting Other Health Insurance Claims

You should submit claims with OHI electronically. You do not need to attach the primary payer’s remittance advice. If you are unable to submit your claim electronically, the remittance advice from the primary insurer must accompany your claim submission to PGBA. Be sure to include the following information:

- The amount paid by the other insurer
- The amount you need to write off according to the OHI’s policies
- A copy of the primary insurer’s remittance advice with TRICARE paper claims; the primary insurer’s remittance advice must contain the following:
  - The definition of any “reason codes” used by the primary payer to describe how the claim was processed, when applicable
  - Information on the action taken by the primary payer for each specific date of service and charges, when applicable

Claims submitted without the listed information will be denied.

**Note:** UnitedHealthcare pays claims with OHI line by line. If the other carrier pays on some lines and not others, UnitedHealthcare will consider each service on its own merit.

**TRICARE Prime Point-of-Service Option (POS)**

POS cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. However, it is required that the beneficiary have prior authorization for certain covered services, whether or not the beneficiary has OHI. For additional information please refer the **Point-of-Service** section in this Handbook.

### Calculating Payments

Payments from the primary payer and TRICARE (as the secondary payer) will not collectively exceed the billed charges.

OHI payments will not exceed the beneficiary liability. TRICARE will pay the beneficiary liability unless that amount is more than the TRICARE-allowable charge.
TRICARE and Third-Party Liability Insurance

The Federal Medical Care Recovery Act allows the government to be reimbursed for costs associated with treating a TRICARE beneficiary who has been injured in an accident caused by someone else.

When a claim appears to have possible third-party involvement, certain actions must be taken that can affect total processing time. UnitedHealthcare is responsible for identifying and investigating all potential third-party recovery claims.

Inpatient claims submitted with diagnosis codes indicating a potential accidental injury or illness will be researched regardless of the billed amount. Claims for professional services that exceed a TRICARE liability of $500 will also be researched. These claims will not be processed further until the beneficiary completes and submits a Statement of Personal Injury – Possible Third Party Liability (DD Form 2527). Providers may wish to print a DD Form 2527 from UHCMilitaryWest.com > Providers > Find a Form > General to facilitate the completion of the form by the beneficiary. There are certain diagnosis codes that are exceptions to the DD Form 2527 submission requirement.

When the claim is received and appears to have possible third-party involvement, as mentioned previously, the following process will occur:

- The DD Form 2527 will be mailed to the beneficiary.

- The claim is pended for up to 35 calendar days. If the DD Form 2527 is not received, the claim may be denied.

The claim will be reprocessed when the DD Form 2527 is completed and returned by the beneficiary. Encourage the beneficiary to fill out the form within the 35 calendar days to avoid payment delays. If the illness or injury was not caused by a third party, but the diagnosis code(s) still falls between 800 and 999 for ICD-9 coding or for ICD-10 codes use S00.00 and T88.9 and ending in the seventh character A, B, or C (indicating initial encounter), the beneficiary may still be responsible to fill out the DD Form 2527. If the form is not returned, the claim will be denied.

If the claim is denied due to lack of submission of the DD Form 2527 by the beneficiary, you may bill the beneficiary.

When the medical records demonstrate that there is no potential for third-party liability and the beneficiary or next of kin has refused to complete the DD Form 2527 or cannot be located by the provider, there is no need to submit a completed DD Form 2527 before the claims are processed. If the DD Form 2527 is not returned and the provider states that there is no potential for third-party liability, UnitedHealthcare shall request copies of medical records. If UnitedHealthcare’s review of the records determines that no potential third-party liability exists, the claim may be processed and paid without a completed DD Form 2527.

TRICARE and Workers’ Compensation

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

Avoiding Collections Activities

Both network and non-network providers are encouraged to explore every possible means to resolve claims issues without involving debt-collection agencies. The most important action you can take for your practice and for TRICARE beneficiaries is to avoid the debt-collection process altogether by following these simple error-checking steps:

1. Review the TRICARE remittance advice when it arrives; if a claim is rejected, it will state the reason.

2. If the remittance advice states that inaccurate beneficiary information is the reason for the denial, it is important to make every attempt to contact the beneficiary to obtain the correct information.

3. If a remittance advice does not arrive within 30 days, this may mean that there has been a problem in submission of the claim. Registered users of UHCMilitaryWest.com may check claims status online. If the patient has Medicare, contact the TRICARE dual-eligible fiscal intermediary, PGBA at 877-988-9378.

4. Secure website users may submit additional or corrected information regarding a rejected claim.

Use the secure area of UHCMilitaryWest.com to verify claims status. Please wait at least 30 days after submitting a claim before contacting UnitedHealthcare. After 30 days you may find assistance on the secure website at UHCMilitaryWest.com or by calling 877-988-9378. Otherwise, network and non-network providers should contact their local TRICARE representatives.
Beneficiaries are responsible for their out-of-pocket expenses. A beneficiary should not be sent to collections before the non-network provider contacts his or her local TRICARE representative, unless the only amount outstanding is the beneficiary’s deductible, cost-share, or copayment amount reflected on the provider remittance advice.

**TRICARE Reimbursement Methodologies**

Reimbursement rates and methodologies are subject to change per DoD guidelines. Refer to the *TRICARE Reimbursement Manual* at manuals.tricare.osd.mil for more information. Providers must use applicable modifiers that fit the description of the service. The CPT and HCPCS publications contain lists of modifiers available for describing services.

**Reimbursement Limit**

Payments made to network providers for medical services rendered to TRICARE beneficiaries shall not exceed 100 percent of the TRICARE-allowable charges.

**CHAMPUS Maximum Allowable Charge**

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) maximum allowable charge (CMAC) 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 when appropriately applied to services priced under CMAC. For more information visit tricare.mil/cmac.

**Site-of-Service Pricing**

TRICARE CMAC changes are variable at the discretion of DHA. The following four categories represent the four classes of providers used for reimbursement:

**Category 1:** Services of medical doctors (MDs), doctors of osteopathy (DOs), optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, audiologists, and applicable outpatient hospital services provided in a facility, including:

- Ambulances
- Ambulatory surgery centers (ASCs)
- Hospices
- Hospitals (outpatient facilities where the hospital is generating a revenue bill; i.e., revenue code 510)
- MTFs
- Psychiatric facilities
- Residential treatment centers
- Skilled nursing facilities (SNFs)

**Category 2:** Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists, and applicable outpatient hospital services provided in a non-facility, including:

- Home settings
- Provider offices
- Other non-facility settings

**Category 3:** Services of all other providers not found in Category 1 provided in a facility.

**Category 4:** Services of all other providers not found in Category 2 provided in a non-facility.

UnitedHealthcare will retain and maintain previous years’ CMAC files for historical purposes. Updated CMAC rates based on site of service are available on the TRICARE website at tricare.mil/cmac. Periodic CMAC changes apply to both network and non-network providers.
CHAMPUS Maximum Allowable Charge Procedure Pricing Calculator

To use the CMAC calculator, go to tricare.mil/cmac and follow the online prompts. For previous years’ CMAC rates, use the applicable Current Procedural Terminology (CPT®) code.

Questions about the pricing calculator application may be sent to Webmaster-CMAC@DHA.osd.mil.

TRICARE-Allowable Charge

The TRICARE-allowable charge is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The allowable charge is the lowest of:

(a) the actual billed charge; (b) the maximum TRICARE-allowable charge; or (c) the UnitedHealthcare Fee Schedule.

For example:

- If the TRICARE-allowable charge for a service is $90 and the billed charge is $50, the TRICARE-allowable charge becomes $50 (the lower of the two charges).
- If the TRICARE-allowable charge for a service is $90, and the billed charge is $100, TRICARE will allow $90 (the lower of the two charges).
- In the case of inpatient hospital payments, the specific hospital reimbursement method applies (e.g., the diagnosis-related group [DRG] rate is the TRICARE-allowable charge regardless of the billed amount, unless otherwise stated in the provider’s contract).
- In the case of outpatient hospital claims subject to the outpatient prospective payment system (OPPS), services will be subject to OPPS ambulatory payment classifications (APCs) where applicable.

UnitedHealthcare State Prevailing Fee Schedule rates are established for codes that have no current available CMAC pricing. The UnitedHealthcare State Prevailing Fee Schedule includes those charges that fall within the range of charges most frequently used in a state for a particular procedure or service. When no maximum allowable charge is available, a UnitedHealthcare State Prevailing Fee Schedule rate is developed for the state in which the service or procedure is provided. Unless a specific exception has been made, these rates are developed on:

- A statewide basis (Localities within states are not used, nor are UnitedHealthcare Fee Schedule rates developed for any area larger than individual states.)
- A non-specialty basis

UnitedHealthcare State Prevailing Fee Schedule rates are developed using a minimum of eight claims submitted for reimbursement to TRICARE. The rate is determined for the service by placing all actual charges billed for the service in an array by ascending order. The lowest charge (in the array) that is high enough to include 80 percent of the cumulative charges (number of claims billed) is determined to be the UnitedHealthcare State Prevailing Fee Schedule rate. For more details, refer to the following:

- myTRICARE.com. (Provider > Learn More > Billing Information > Coding > West Region State Prevailing Rates, then ‘Select State’).
- the TRICARE Reimbursement Manual, Chapter 5, Section 1 at manuals.tricare.osd.mil.

If a minimum of eight claims has not been received, the prevailing rate can be determined through the use of information about the volume of business done by various providers or suppliers within the TRICARE West Region or through available price lists and supply catalogs.

Examples of codes that do not have a CMAC rate but may have a state prevailing rate include:

- Ambulance services (as of Oct. 1, 2013, follows CMS Ambulance fee schedules.)
- G-codes (for procedures that do not have CPT codes)
- Q-codes (supplies for casts)
- S-codes (services and supplies with no national codes). **Note:** With limited exceptions, TRICARE no longer accepts S (temporary) codes unless specified in policy. See the No Government Pay Procedure Code List, which is available at tricare.mil/nogovernmentpay.
This reimbursement schedule allows providers to know the reimbursement rates for various non-CMAC codes in advance and supports that UnitedHealthcare applies consistent pricing. If CMAC rates are subsequently established for any codes on this reimbursement schedule, which had previously been set by UnitedHealthcare, the new CMAC rate will supersede and govern the reimbursement for these services. The reimbursement schedule will be updated as needed by UnitedHealthcare, or as new codes are added.

For most services, the reimbursement rate is based on the state/location where the services are provided. To find the reimbursement rate for a particular code that does not have a CMAC rate established visit tricare.mil/cmac.

**Anesthesia Rates**

TRICARE reimbursement of anesthesia services is calculated using the number of time units, the Medicare relative value units (RVUs), and the anesthesia conversion factor.

TRICARE allows for payment of anesthesia services using standard industry modifiers.

**Anesthesia Claims and Reimbursement**

Professional anesthesia claims must be submitted on an appropriate Form 1500, using the applicable CPT anesthesia codes. If applicable, the claim must also be billed with the appropriate physical status (P) modifier. The use of other optional modifiers may also be appropriate. An anesthesia claim must specify who provided the anesthesia service. In cases where a portion of the anesthesia service is provided by an anesthesiologist and a nurse anesthetist performs the remainder, the claim must identify exactly which services were provided by each provider. This distinction may be made by the use of modifiers.

**Calculating Anesthesia Reimbursement**

The following formula is used to calculate the TRICARE anesthesia reimbursement: (Time Units + RVUs) X Conversion Factor = reimbursement amount.

**Base unit:** TRICARE anesthesia reimbursement is determined by calculating a base unit, derived from the Medicare Anesthesia Relative Value Guide. 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 non-invasive monitoring (e.g., electrocardiogram, temperature, blood pressure, oximetry, capnography, 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

Placement of arterial, central venous, and pulmonary artery catheters and use of transesophageal echocardiography are not included in the base-unit value. 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 determined in 15-minute increments. Any fraction of a unit is considered a whole unit. Anesthesia time starts when the anesthesiologist begins to prepare the beneficiary for anesthesia care in the operating room or in an equivalent area. It ends when the anesthesiologist is no longer in personal attendance and the beneficiary may be safely placed under post-anesthesia supervision. Providers must indicate the number of time units in Column 24G (Days or Units) of the Form 1500.

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

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

**Anesthesia Procedure Pricing Calculator**

Visit tricare.mil/anesthesia for an anesthesia rate calculator. You may also access the calculator at tricare.mil/provider > What TRICARE Pays > Anesthesia Rates.
Ambulatory Surgery Grouper Rates
Freestanding ASCs and other providers exempt from TRICARE OPPS are reimbursed under the grouper rate methodology.

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

Ambulatory Surgery Center Charges
All hospitals and freestanding ASCs must submit claims for surgery procedures on a UB-04 claim form.

Ambulatory Surgery Center Reimbursement
All procedures are approved on the basis of medical necessity.

For additional information, ambulatory surgery providers may view reimbursements at tricare.mil/ambulatory. All groupers are defined by DHA at tricare.mil/ambulatory or at tricare.mil/opps, depending on the hospital’s reimbursement type.

Important points to remember about ASC groupers and reimbursement:

• Providers should bill the surgeries performed and not use unclassified codes.
• ASC groupers are priced based on CPT codes.
• TRICARE multiple surgery guidelines are based on the highest allowable and not ClaimCheck® guidelines.
• ASC claims are reimbursed based on a grouper rate or billed charges, as appropriate.
• UnitedHealthcare reimburses some services in addition to the grouper rate (e.g., certain labs, X-rays, implants). All services require appropriate CPT/HCPCS coding. Unlisted codes require authorization and must include a complete description.

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

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

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

Diagnosis-Related Group Reimbursement (DRG)
DRG reimbursement is a reimbursement system for inpatient charges from facilities. This system assigns payment levels to each DRG based on the average cost of treating all TRICARE beneficiaries in a given DRG. The TRICARE DRG-based payment system is modeled on the Medicare inpatient prospective payment system (PPS). Cases are classified into the appropriate DRG by a grouper program.

The grouper used for the TRICARE DRG-based payment system is the same as the Medicare grouper with some modifications such as neonate DRGs. Refer to the TRICARE Reimbursement Manual at manuals.tricare.osd.mil for detailed information.

TRICARE uses the TRICARE Severity DRG payment system, which is modeled on the Medical Severity DRG payment system. Present-on-admission indicators are required on all DRG claims. Hospital-acquired conditions, as identified by Medicare, will not be reimbursed.

Note: Critical access hospitals (CAHs) are reimbursed using the reasonable cost method, and are exempt from the DRG-based payment system. For more information, refer to the TRICARE Reimbursement Manual, Chapter 15, Section 1 at manuals.tricare.osd.mil.
Special Eligibility Rules under DRG

Under the TRICARE Standard DRG payment system, if a patient loses or gains eligibility during a hospitalization, the DRG hospital will be paid as if the patient were eligible during the entire admission. If the patient becomes entitled to Medicare Part A and Medicare Part B coverage, Medicare is the first payer and TRICARE becomes the secondary payer. For a patient who becomes eligible for Medicare because of age, and who is not an ADFM, TRICARE’s secondary pay status is for that claim only. However, a change in eligibility often will affect outlier payments. The patient’s cost-share will be based on the status of the sponsor (active duty or retired) at the time of admission.

For all other providers, including DRG-exempt hospitals, TRICARE Standard will share the cost of only that portion of the services or supplies that were rendered before eligibility ceased.

Present on Admission Indicator

Inpatient acute care hospitals that are paid under the TRICARE DRG-based payment system are required to report a present on admission (POA) indicator for both primary and secondary diagnoses on inpatient acute care hospital claims. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. Any hospital-acquired conditions, as identified by Medicare, will not be reimbursed. A list of hospital-acquired conditions can be found at tricare.mil/drgrates.

Any claim that does not report a valid POA indicator for each diagnosis on the claim will be denied. The five valid POA codes are described in Figure 10.1.

Present on Admission Code Descriptions

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Indicates that the condition was present on admission.</td>
</tr>
<tr>
<td>W</td>
<td>Affirms that the provider has determined, based on data and clinical judgment, that it is not possible to document when the onset of the condition occurred.</td>
</tr>
<tr>
<td>N</td>
<td>Indicates that the condition was not present on admission.</td>
</tr>
<tr>
<td>U</td>
<td>Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.</td>
</tr>
</tbody>
</table>

The following hospitals are exempt from POA reporting for TRICARE:

- CAHs
- Long-term care hospitals
- Cancer hospitals
- Children’s inpatient hospitals
- Inpatient rehabilitation hospitals
- Psychiatric hospitals and psychiatric units
- Sole community hospitals (SCHs)
- VA hospitals

DRG Calculator

The DRG calculator is available at tricare.mil/drgrates.

You may locate the indirect medical education (IDME) factor (for teaching hospitals only) and wage index information using the Wage Indexes and IDME Factors File that are also available on the DRG web page. If a hospital is not listed in the Wage Indexes and IDME Factors File, use the ZIP to Wage Index File to obtain the wage index for that area by ZIP code.
Request for DRG Reimbursement Adjustment
If a DRG-reimbursed claim is submitted incorrectly, a hospital may request an adjustment by filing a corrected claim. Adjustment requests must be sent directly to PGBA within 60 days of the date the claim is processed. This date can be determined by looking at the remittance advice.

A change in the principal diagnosis or sequencing of the diagnosis or procedures may result in a higher-weighted DRG and a higher reimbursement rate. In these cases, the hospital provider should carefully review these cases. After review, providers who are registered users of UHCMilitaryWest.com should submit their adjustment requests. The request and related information may be submitted to:

TRICARE West Region
Correspondence Department
P.O. Box 7065
Camden, SC 29021-7065

When submitting the adjustment rate, the hospital must also provide the following supporting documentation:

• A copy of the original remittance advice
• Corrections initialed and dated on the claim by facility billing staff
• The codes submitted for adjustment
• An explanation of why the original codes were submitted incorrectly
• A copy of the adjusted UB-04
• A copy of the medical record as required for performing admission review and DRG validation
• Copies of any newly acquired information on which coding changes are based

For more information, refer to the TRICARE Reimbursement Manual, Chapter 6, at manuals.tricare.osd.mil.

These rules apply only to claims submitted incorrectly by a provider. Only adjusted claims resulting in a higher-weighted DRG will be reviewed. Cases that do not regroup will be returned to the hospital without review.

Institutions Exempt from Medicare Prospective Payment System
Hospitals excluded from the Medicare PPS also will be exempt from the TRICARE DRG reimbursement methodology for inpatient charges. Facilities excluded from the TRICARE DRG reimbursement methodology include the following:

• Cancer hospitals
• Christian Science sanatoria
• CAH
• Hospitals outside the 50 United States, the District of Columbia, or Puerto Rico
• Hospitals within hospitals
• Long-term care hospitals
• Psychiatric hospitals or units
• Rehabilitation hospitals or units
• Satellite facilities
• SCHs

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.

All initial requests for reimbursement under capital and direct medical education costs must be submitted to PGBA on or before
the last day of the 12th month following the close of the hospital’s cost-reporting period. The request shall cover the one year period corresponding to 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 report the following:

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

The submission must include a statement certifying that any changes, if applicable, were made as a result of a review, audit, or appeal of the provider’s Medicare cost report. The change(s) shall be reported to PGBA within 30 days of the date the hospital is notified of the change. Additionally, an officer or administrator of the provider must certify all cost reports. Providers should submit requests for reimbursement of capital and direct medical education costs to:

TRICARE West Region
PGBA Finance, AG-740
Capital and Direct Medical Education Reimbursement
P.O. Box 100250
Columbia, SC 29202

**Bonus Payments in Health Professional Shortage Areas**

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

Providers may determine if they are in an HPSA by accessing the U.S. Department of Health and Human Services, Bureau of Health Professions’ HPSA search tool at hpsafind.hrsa.gov. There is also bonus payment information, including HPSA designations, on the CMS website at cms.hhs.gov/HPSAPSAPhysicianBonuses.

**How Bonus Payments Are Calculated**

For providers who are eligible and located in an HPSA, UnitedHealthcare’s claims processor, PGBA will calculate a quarterly 10 percent bonus payment from the total paid amount for TRICARE claims that contain the modifier AQ (Health Professional Shortage Area) in Box 24D of the Form 1500. Bonus payments will be calculated on TRICARE Prime, TPR, TPRADFM, TRICARE Standard and TRICARE Extra, TRS, TRR, and TYA claims, and the amount paid by the government on other health insurance claims.
When submitting a claim for the bonus payment, providers must include the AQ CPT modifier in Box 24D of the Form 1500. For CPT codes with multiple modifiers, place the AQ modifier last. Only the professional component will be used in the calculation of the bonus payment for services that contain both a professional and technical component. Those providers who are eligible and do not submit claims with the appropriate modifier will not receive the bonus payment from TRICARE. There are no retroactive payments, adjustments, or appeals for obtaining a bonus payment, so include the bonus payment modifier with your initial claims submission if you are eligible.

**Note:** Although Medicare no longer requires the use of modifiers, TRICARE still requires their use. If claims are submitted without the modifier, your bonus payment cannot be paid.

### Skilled Nursing Facility Pricing

SNFs are paid 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. Prior authorization is required for SNF admissions and continued stay reviews. Failure to obtain authorization or submit clinical information to complete the review upon request from UnitedHealthcare subjects the claim to a penalty. SNF admissions for children under age 10 and CAH swing beds are exempt from SNF PPS and are reimbursed based on DRG or contracted rates.

For more information about SNF PPS, refer to the *TRICARE Reimbursement Manual*, Chapter 8, Section 2 at manuals.tricare.osd.mil.

### Home Health Agency Pricing

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

All home health services require prior authorization from UnitedHealthcare and renewal every 60 days. In order 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.

**Exceptions**

Beneficiaries enrolled in the Custodial Care Transition Program (CCTP) are exempt from Home Health PPS, and providers treating them may continue billing as always (fee for service). For details about beneficiaries grandfathered under the CCTP, refer to the *TRICARE Policy Manual*, Chapter 8, Section 15.1 at manuals.tricare.osd.mil.

### Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Pricing

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) prices are established by using the Medicare fee schedules, reasonable charges, UnitedHealthcare Fee Schedule, or average wholesale pricing. Most payments of DMEPOS are based on the fee schedule established for each DMEPOS item. The services and/or supplies are coded using CMS HCPCS Level II codes that begin with the letters:

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

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

The following modifiers are to be used to identify repair and replacement of an item:

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

In addition to rates for DMEPOS, enteral and parenteral nutrition items are also included in the DMEPOS fee schedule.

Links to the appropriate Medicare DMEPOS fee schedules may be found on tricare.mil/tma/Rates > Rates and Reimbursement > Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS).

Providers in Colorado, New Mexico, and Texas should refer to PGBA, the Medicare Region C payer, at pgba.com for reimbursement information. Providers in Minnesota should refer to National Government Services at ngsmedicare.com, and providers in all other states should refer to Noridian Administrative Services, LLC, at noridianmedicare.com.

Home Infusion Drug Pricing
Home infusion drugs are those drugs (including chemotherapy drugs) administered in the home by other than oral means (i.e., the drug must be administered either intramuscularly, subcutaneously, intravenously, or infused through a piece of DME). DME verification is not required.

Home infusion drugs must be billed using an appropriate “J” 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 of the administered drug.

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 acting within the scope of his or her license who actively assists the operating surgeon in the performance of a covered surgical service. TRICARE covers assistant surgeon services when the services are considered medically necessary and meet the following criteria:

• The complexity of the surgical procedure warrants an assistant surgeon rather than a surgical nurse or other operating room personnel

• Interns, residents, or other hospital staff are unavailable at the time of the surgery

All assistant surgeon claims are subject to medical review and need verification that the surgical procedure(s) performed required the services of an assistant surgeon and were medically necessary.

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 a provider bills for a procedure or service performed by a PA, TRICARE policy requires that the supervising or employing physician 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 their own behalf and use their NP provider number for procedures or services they perform.

Providers should use the modifier that best describes the assistant surgeon services provided in Box 24D on the Form 1500:

• “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.

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

Hospice Pricing
The hospice program must enter into an agreement with TRICARE to be eligible for payment. National Medicare hospice rates will be used for reimbursement of each of the following levels of care provided by, or under arrangement with, a Medicare-approved hospice program:
• Routine home care
• Continuous home care
• Inpatient respite care
• General inpatient care

**Note:** Reimbursement can be extended for routine and continuous hospice care provided to beneficiaries residing in a nursing home facility, that is, physician, nurse, social worker, and home health aide visits to patients requiring palliative care for terminal illnesses. TRICARE will not pay for the room and board charges of the nursing home.

The hospice will be reimbursed for the amount applicable to the type and intensity of the services furnished to the beneficiary on a particular day. One rate will be paid for each level of care, except for continuous home care, which will be reimbursed based on the number of hours of continuous care furnished to the beneficiary on a given day.

**Note:** Continuous home care must be equal to or greater than eight hours per day, midnight to midnight, with at least 50 percent of the care provided by licensed practical nursing or registered nursing staff.

The rates will be adjusted for regional differences using appropriate Medicare area wage indexes.

The national 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 the locally adjusted national payment rates and not considered hospice services will be for direct patient care services rendered by an independent attending physician.

The hospice will bill for its physician charges/services (physicians under contract with the hospice program) on a UB-04 using the appropriate revenue code of 657 and the appropriate CPT codes.

Independent attending physician services or patient care services rendered by a physician not under contract with or employed by the hospice are not considered a part of the hospice benefit and are not included in the cap amount calculations. The provider will bill for these services on a Form 1500 using the appropriate CPT codes. These services will be subject to standard TRICARE reimbursement and cost-sharing/deductible provisions.

**Outpatient Prospective Payment System (OPPS)**

TRICARE OPPS was implemented to pay claims for hospital outpatient services.

TRICARE OPPS is mandatory for both network and non-network providers and applies to all hospitals participating in the Medicare program, with some exceptions (e.g., CAHs, cancer hospitals, children's hospitals).

TRICARE OPPS also applies to hospital-based partial hospitalization programs (PHPs) subject to TRICARE’s prior authorization requirements, and hospitals (or distinct parts thereof) that are excluded from the inpatient DRG-based payment system, to the extent the hospital (or distinct part thereof) furnishes outpatient services.

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

• Critical Access Hospitals (CAH)
• Hospitals located outside the 50 United States, the District of Columbia, and Puerto Rico
• Indian Health Service hospitals that provide outpatient services
• Specialty care providers, including:
  › Cancer and children’s hospitals
  › Community mental health centers
  › Comprehensive outpatient rehabilitation facilities
  › Freestanding ambulatory surgery centers (ASC)
  › Freestanding birthing centers
  › Freestanding end-stage renal disease facilities
OPPS implementation in rural areas for small hospitals with fewer than 100 beds and SCHs began Jan. 1, 2010, when the Medicare transitional corridor payments for these hospitals expired.

For more information on TRICARE OPPS implementation, refer to the TRICARE Reimbursement Manual, Chapter 13 at manuals.tricare.osd.mil You may also visit tricare.mil/opps.

**Temporary Transitional Payment Adjustments**

Temporary Transitional Payment Adjustments (TTPAs) are in place for all hospitals, both network and non-network, to buffer the initial decline in payments upon implementation of TRICARE OPPS. For network hospitals, the TTPAs cover a four year period. The four-year transition sets higher payment percentages for the 10 APC codes for emergency room (ER) and hospital clinic visits (APC codes 604–609 and 613–616), with reductions in each transition year.

For non-network hospitals, the TTPAs cover a three year period, with reductions in each transition year.

Figure 10.2 shows the TTPA percentages for APC codes 604–609 and 613–616 during the four-year network hospital and three-year non-network hospital transition periods.

<table>
<thead>
<tr>
<th>Transition Period</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1, 2009 – April 30, 2010</td>
<td>200 ER</td>
<td>140 ER</td>
</tr>
<tr>
<td>May 1, 2009 – April 30, 2010</td>
<td>175 Hospital Clinic</td>
<td>125 Hospital Clinic</td>
</tr>
<tr>
<td>May 1, 2011 – April 30, 2012</td>
<td>150 ER</td>
<td>110 ER</td>
</tr>
<tr>
<td>May 1, 2012 – April 30, 2013</td>
<td>130 ER</td>
<td>100 ER</td>
</tr>
<tr>
<td>May 1, 2013 – April 30, 2014</td>
<td>100 ER</td>
<td>100 ER</td>
</tr>
</tbody>
</table>

1. The transition period for network hospitals is four years. In year five, TRICARE’s payment level will be the same as Medicare's (i.e., 100 percent).
2. The transition period for non-network hospitals is three years. In year four, TRICARE’s payment level will be the same as Medicare's (i.e., 100 percent).

**Temporary Military Contingency Payment Adjustments**

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

Reimbursement rates and methodologies are subject to change per DoD guidelines. TRICARE rates are subject to change on at least an annual basis. Rate changes are usually effective on the dates listed in Figure 10.3.

### TRICARE Rates Update Schedule

<table>
<thead>
<tr>
<th>Update Frequency</th>
<th>Rates Scheduled to Change</th>
</tr>
</thead>
</table>
| Variable at DHA’s discretion | • CMAC (may be adjusted quarterly)  
• Anesthesia |
| April 1 | • Birthing centers |
| Oct. 1 | • DRG  
• Residential treatment centers  
• Mental health  
• SNF PPS (may be adjusted quarterly)  
• Inpatient hospital copayments and cost-shares  
• Hospice |
| Nov. 1 | • Ambulatory surgery grouper |
| Dec. 1 | • CAH |
| Jan. 1 | • Sole Community Hospital Inpatient |
| Quarterly (Jan., April, July, Oct.) | • DMEPOS  
• Home health PPS  
• OPPS coding |
| Quarterly (Feb., May, Aug., Nov.) | • Injectables and immunizations |

DoD has adjusted the TRICARE reimbursement rates to mirror Medicare’s levels. Updated rates and weights are available at tricare.mil/tma.

### No Government Pay Procedure Code List

The No Government Pay Procedure Code List is a list of codes that are excluded from coverage and are not payable under the TRICARE program. For the most up-to-date No Government Pay Procedure Code List, visit tricare.mil/nogovernmentpay.

### Inpatient-Only List

For OPPS, non-OPPS, and professional providers, payment will not be made for procedures that are designated as “Inpatient Only.” The list of HCPCS codes on the Inpatient-Only List specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient.

For the most up-to-date Inpatient-Only List, visit health.mil/inpatientprocedures.
## Provider Tools

### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABA</td>
<td>Applied behavior analysis</td>
</tr>
<tr>
<td>ACIP</td>
<td>Advisory Committee on Immunization Practices</td>
</tr>
<tr>
<td>ADDP</td>
<td>Active Duty Dental Program</td>
</tr>
<tr>
<td>ADFM</td>
<td>Active duty family member</td>
</tr>
<tr>
<td>ADOS-2</td>
<td>Autism Diagnostic Observation Schedule, Second Edition</td>
</tr>
<tr>
<td>ADSM</td>
<td>Active duty service member</td>
</tr>
<tr>
<td>APC</td>
<td>Ambulatory Payment Classification</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory surgery center</td>
</tr>
<tr>
<td>BCaBA</td>
<td>Board Certified Assistant Behavior Analyst-Bachelor level</td>
</tr>
<tr>
<td>BCBA</td>
<td>Board Certified Behavior Analyst-Masters level</td>
</tr>
<tr>
<td>BCBA-D</td>
<td>Board Certified Behavior Analyst-Doctoral level</td>
</tr>
<tr>
<td>BMI</td>
<td>Body-mass index</td>
</tr>
<tr>
<td>CAC</td>
<td>Common Access Card</td>
</tr>
<tr>
<td>CAH</td>
<td>Critical access hospital</td>
</tr>
<tr>
<td>CCTP</td>
<td>Custodial Care Transition Program</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
</tr>
<tr>
<td>CHAMPUS</td>
<td>Civilian Health and Medical Program of the Uniformed Services</td>
</tr>
<tr>
<td>CHAMPVA</td>
<td>Civilian Health and Medical Program of the Department of Veterans Affairs</td>
</tr>
<tr>
<td>CHCBP</td>
<td>Continued Health Care Benefit Program</td>
</tr>
<tr>
<td>CMAC</td>
<td>CHAMPUS maximum allowable charge</td>
</tr>
<tr>
<td>CMN</td>
<td>Certificate of medical necessity</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>COB</td>
<td>Coordination of Benefits</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>CQM</td>
<td>Clinical quality management</td>
</tr>
<tr>
<td>CQMP</td>
<td>Clinical Quality Management Program</td>
</tr>
<tr>
<td>CTC</td>
<td>Computed tomographic colonography</td>
</tr>
<tr>
<td>DBN</td>
<td>DoD Benefits Number</td>
</tr>
<tr>
<td>DEERS</td>
<td>Defense Enrollment Eligibility Reporting System</td>
</tr>
<tr>
<td>DHA</td>
<td>Defense Health Agency</td>
</tr>
<tr>
<td>DME</td>
<td>Durable medical equipment</td>
</tr>
<tr>
<td>DMEPOS</td>
<td>Durable medical equipment, prosthetics, orthotics, and supplies</td>
</tr>
<tr>
<td>DNA</td>
<td>Deoxyribonucleic acid</td>
</tr>
<tr>
<td>DO</td>
<td>Doctor of osteopathy</td>
</tr>
<tr>
<td>DoD</td>
<td>Department of Defense</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis-related group</td>
</tr>
<tr>
<td>DSM-5</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, 5th Edition</td>
</tr>
<tr>
<td>DTF</td>
<td>Dental treatment facility</td>
</tr>
<tr>
<td>E&amp;M</td>
<td>Evaluation and management</td>
</tr>
<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>ECHO</td>
<td>Extended Care Health Option</td>
</tr>
<tr>
<td>ECT</td>
<td>Electroconvulsive therapy</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic data interchange</td>
</tr>
<tr>
<td>EFMP</td>
<td>Exceptional Family Member Program</td>
</tr>
<tr>
<td>EFT</td>
<td>Electronic funds transfer</td>
</tr>
<tr>
<td>EHHC</td>
<td>ECHO Home Health Care</td>
</tr>
<tr>
<td>EIA</td>
<td>Educational Interventions for Autism</td>
</tr>
<tr>
<td>EIN</td>
<td>Employer identification number</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of benefits</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency room</td>
</tr>
<tr>
<td>ERA</td>
<td>Electronic remittance advice</td>
</tr>
<tr>
<td>FDA</td>
<td>U.S. Food and Drug Administration</td>
</tr>
<tr>
<td>FL</td>
<td>Form Locator</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal year</td>
</tr>
<tr>
<td>GDFT</td>
<td>Geographically distant family members</td>
</tr>
<tr>
<td>HbA1c</td>
<td>Hemoglobin A1c</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Healthcare Effectiveness Data and Information Set</td>
</tr>
<tr>
<td>HHA</td>
<td>Home health agency</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
</tr>
<tr>
<td>HITECH</td>
<td>Health Information Technology for Economic and Clinical Health</td>
</tr>
<tr>
<td>HNPPCC</td>
<td>Hereditary non-polyposis colorectal cancer</td>
</tr>
<tr>
<td>HPSA</td>
<td>Health Professional Shortage Areas</td>
</tr>
<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
</tr>
<tr>
<td>HUAM</td>
<td>Home uterine activity monitoring</td>
</tr>
<tr>
<td>ID</td>
<td>Identification</td>
</tr>
<tr>
<td>IDME</td>
<td>Indirect medical education</td>
</tr>
<tr>
<td>IRS</td>
<td>Internal Revenue Service</td>
</tr>
<tr>
<td>IVR</td>
<td>Interactive voice response</td>
</tr>
<tr>
<td>LCSW</td>
<td>Licensed clinical social worker</td>
</tr>
<tr>
<td>LOD</td>
<td>Line of duty</td>
</tr>
<tr>
<td>MCC</td>
<td>Member Choice Center</td>
</tr>
<tr>
<td>MD</td>
<td>Medical doctor</td>
</tr>
<tr>
<td>MHS</td>
<td>Military Health System</td>
</tr>
<tr>
<td>MMWSO</td>
<td>Military Medical Support Office -See R&amp;SMSO-GL</td>
</tr>
<tr>
<td>MMWR</td>
<td>Morbidity and Mortality Weekly Report</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td>MTF</td>
<td>Military treatment facility</td>
</tr>
<tr>
<td>NADFM</td>
<td>Non-active duty family member</td>
</tr>
<tr>
<td>NADSM</td>
<td>Non-active duty service member</td>
</tr>
<tr>
<td>NATO</td>
<td>North Atlantic Treaty Organization</td>
</tr>
<tr>
<td>NCI</td>
<td>National Cancer Institute</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>NDC</td>
<td>National Drug Code</td>
</tr>
<tr>
<td>NOC</td>
<td>Not otherwise categorized</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>NPPES</td>
<td>National Plan and Provider Enumeration System</td>
</tr>
<tr>
<td>OHI</td>
<td>Other health insurance</td>
</tr>
<tr>
<td>OPPS</td>
<td>Outpatient prospective payment system</td>
</tr>
<tr>
<td>P&amp;T</td>
<td>Pharmacy and Therapeutics</td>
</tr>
<tr>
<td>PA</td>
<td>Physician assistant</td>
</tr>
<tr>
<td>PCM</td>
<td>Primary care manager</td>
</tr>
<tr>
<td>PDTS</td>
<td>Pharmacy Data Transaction Service</td>
</tr>
<tr>
<td>PHI</td>
<td>Protected health information</td>
</tr>
<tr>
<td>PHP</td>
<td>Partial hospitalization program</td>
</tr>
<tr>
<td>POA</td>
<td>Present on admission</td>
</tr>
<tr>
<td>POS</td>
<td>Point-of-service</td>
</tr>
<tr>
<td>PPS</td>
<td>Prospective payment system</td>
</tr>
<tr>
<td>PSA</td>
<td>Prime Service Area</td>
</tr>
<tr>
<td>PSPR</td>
<td>Post-service prepayment review</td>
</tr>
<tr>
<td>R&amp;SMSO-GL</td>
<td>Reserve and Service Member Support Office Great Lakes</td>
</tr>
<tr>
<td>RN</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>ROFR</td>
<td>Right of first refusal</td>
</tr>
<tr>
<td>RT</td>
<td>Respiratory therapist</td>
</tr>
<tr>
<td>RTC</td>
<td>Residential treatment center</td>
</tr>
<tr>
<td>RVU</td>
<td>Relative value unit</td>
</tr>
<tr>
<td>SCH</td>
<td>Sole community hospital</td>
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<tr>
<td>SHCP</td>
<td>Supplemental Health Care Program</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled nursing facility</td>
</tr>
<tr>
<td>SPOC</td>
<td>Service point of contact</td>
</tr>
<tr>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>SSN</td>
<td>Social Security number</td>
</tr>
<tr>
<td>SUDRF</td>
<td>Substance use disorder rehabilitation facility</td>
</tr>
<tr>
<td>TAMP</td>
<td>Transitional Assistance Management Program</td>
</tr>
<tr>
<td>TCSRC</td>
<td>Transitional Care for Service-Related Conditions</td>
</tr>
<tr>
<td>TDP</td>
<td>TRICARE Dental Program</td>
</tr>
<tr>
<td>TFL</td>
<td>TRICARE For Life</td>
</tr>
<tr>
<td>TIN</td>
<td>Tax Identification Number</td>
</tr>
<tr>
<td>TMCPA</td>
<td>Temporary Military Contingency Payment Adjustment</td>
</tr>
<tr>
<td>TOP</td>
<td>TRICARE Overseas Program</td>
</tr>
<tr>
<td>TPR</td>
<td>TRICARE Prime Remote</td>
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<tr>
<td>TPRADFM</td>
<td>TRICARE Prime Remote for Active Duty Family Members</td>
</tr>
<tr>
<td>TQMC</td>
<td>TRICARE Quality Monitoring Contractor</td>
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<td>TRDP</td>
<td>TRICARE Retiree Dental Program</td>
</tr>
<tr>
<td>TRIAP</td>
<td>TRICARE Assistance Program</td>
</tr>
<tr>
<td>TRR</td>
<td>TRICARE Retired Reserve</td>
</tr>
<tr>
<td>TRS</td>
<td>TRICARE Reserve Select</td>
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<tr>
<td>TTPA</td>
<td>Temporary Transitional Payment Adjustment</td>
</tr>
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<td>TYA</td>
<td>TRICARE Young Adult</td>
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<tr>
<td>UHM</td>
<td>Utilization Management</td>
</tr>
<tr>
<td>USFHP</td>
<td>US Family Health Plan</td>
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<tr>
<td>VA</td>
<td>U.S. Department of Veterans Affairs</td>
</tr>
<tr>
<td>Vineland II</td>
<td>Vineland Adaptive Behavior Scales, Second Edition</td>
</tr>
<tr>
<td>WPS</td>
<td>Wisconsin Physicians Service</td>
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</tbody>
</table>
### Glossary of Terms

**Accepting assignment**
Accepting assignment refers to when a provider agrees to accept the TRICARE allowable charge as payment in full. Network providers accept assignment on all claims and non-network providers may choose to accept assignment on a claim-by-claim basis.

**Authorized Provider**
See below, under “Provider Types.”

**Balance billing**
When a provider bills a beneficiary for the difference between billed charges and the TRICARE allowable charge after TRICARE (and other health insurance) has paid everything it is going to pay. Providers are prohibited from balance billing.

**Base Realignment and Closure Commission (BRAC) Site**
A military base that has been closed or targeted for closure by the government.

**Beneficiary**
A beneficiary is a person who is eligible and enrolled (if required) to receive Covered Services under the TRICARE Program at the time services are rendered. Beneficiaries include active duty family members and retired service members and their families. Other beneficiary categories are listed in the TRICARE Eligibility section of this handbook.

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

**Catastrophic cap**
The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given fiscal year (Oct. 1 – Sept. 30). Point-of-service (POS) cost-shares and the POS deductible are not applied to the catastrophic cap.

**Catchment Area**
Geographic areas determined by the Assistant Secretary of Defense (Health Affairs) that are defined by a set of five-digit ZIP codes, usually within an approximate 40-mile radius of a military inpatient treatment facility. Note: TRICARE Prime is required to be offered in each catchment area.

**Certified provider**
See below, under “Provider Types.”

**CHAMPUS Maximum Allowable Charge (CMAC)**
The Civilian Health and Medicaid Program of the Uniformed Services (CHAMPUS) maximum allowable charge (CMAC) 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 when appropriately applied to services priced under CMAC.

**Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)**
The former health care program established to provide health care coverage for active duty family members and retirees and their family members. TRICARE was organized as a separate office under the Assistant Secretary of Defense and replaced CHAMPUS in 1994.

**Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)**
Civilian Health and Medical Program of the Department of Veterans Affairs is the federal health benefits program for family members of 100-percent totally and permanently disabled Veterans. Civilian Health and Medical Program of the Department of Veterans Affairs is administered by the Department of Veterans Affairs (VA) and is not associated with the TRICARE program. For questions regarding CHAMPVA, call 800-733-8387 or e-mail hac.inqu@va.gov.
ClaimCheck®
A customized, automated claims auditing system that verifies coding accuracy of professional claims. ClaimCheck®, is a registered trademark of McKesson Corporation. All rights reserved.

Corporate services provider
See below, under “Provider Types.”

Credentialing
The process that evaluates and subsequently allows providers 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)
The DEERS database consists 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. The DEERS database is the official record system for TRICARE eligibility.

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

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

Department of Defense Benefits Number (DBN)
The DBN is a unique identifying number on military identification (ID) cards of those eligible to receive military benefits. The DBN replaces Social Security numbers (SSNs) on military ID cards. The DBN is an 11-digit number that relates to TRICARE benefit eligibility. The DBN should be used for medical care and claims, as well as other military benefits such as the commissary. This number is located on the back of the ID card, at the top and is different than the 10-digit DoD ID number also contained on the card.

Extended Care Health Option (ECHO)
The ECHO program is a supplemental program to the TRICARE basic program. It provides eligible active duty family members with additional financial resources for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the beneficiary’s qualifying condition. Qualifying conditions may include moderate or severe mental retardation, a serious physical disability or an extraordinary physical or psychological condition such that the beneficiary is homebound.

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

Grievance
A grievance is a written complaint or concern from a TRICARE beneficiary or a provider on a non-appealable issue. Please refer to the Grievances section of this Handbook for more detailed information.

Initial denial
A written decision or EOB denying a TRICARE claim, a request for prior authorization or a request by a provider for approval as an authorized TRICARE provider, on the basis that the service or provider does not meet TRICARE coverage criteria.
**Managed care support contractor (MCSC)**

A civilian health care partner of the Military Health System that administers TRICARE in one of the TRICARE regions. An MCSC (for example, UnitedHealthcare Military & Veterans) helps combine the services available at MTFs with those offered by the TRICARE network of civilian hospitals and providers to meet the health care needs of TRICARE beneficiaries.

**Medical emergency**

TRICARE defines an emergency as a medical, maternity or behavioral health condition that would lead a layperson to believe a serious medical condition exists; the absence of immediate medical attention would result in a threat to life, limb or sight; when a person has severe, painful symptoms requiring immediate attention to relieve suffering; or when a person is at immediate risk to self or others.

**Military treatment facility**

An MTF is a medical facility (hospital, clinic, etc.) owned and operated by the uniformed services and usually located on or near a military base.

**Non-availability statement**

A non-availability statement (NAS) is a certification from a MTF stating that a specific health care service or procedure cannot be provided at the facility concerned because the necessary resources are not available in the timeframe needed.

**Other health insurance (OHI)**

Any non-TRICARE health insurance that is not considered a supplement is considered OHI. This insurance is acquired through an employer, entitlement program or other source. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, State Victims of Crime Compensation Programs, the Indian Health Service or other programs or plans as identified by DHA.

**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 payment 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.

**Point of service (POS)**

An option that allows TRICARE Prime or TPR beneficiaries to obtain medically necessary services – inside or outside the TRICARE network – from someone other than their primary care manager (PCM) without first obtaining a prior authorization or referral.

Utilizing the POS option results in a deductible and higher out-of-pocket expense for the beneficiary. The POS option does not apply to active duty service members.

**Primary care manager (PCM)**

A TRICARE civilian network provider or MTF provider who provides primary care services to TRICARE Prime and TPR beneficiaries. A PCM is either selected by the beneficiary or assigned by an MTF Commander or his or her designated appointee. TRICARE Prime Remote beneficiaries may choose a non-network provider if a network provider is not available.

**Prime service area (PSA)**

A TRICARE Prime service area (PSA) is a grouping of ZIP codes in which TRICARE Prime is available. Per government specifications, a PSA includes all ZIP codes lying within or intersected by the 40-mile radius around designated MTFs or other areas with a high concentration of TRICARE beneficiaries as a result of past Base Realignment and Closure (BRAC) actions.
Provider Types for TRICARE

Authorized provider
A provider who meets TRICARE’s licensing and certification requirements and has been authorized by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (such as laboratory and radiology providers), and pharmacies.

Certified provider
A hospital or institutional provider, physician, or other individual professional provider of services or supplies specifically authorized by 32 CFR 199.6, that have been verified by DHA or UnitedHealthcare Military & Veterans to meet the standard of 32 CFR 199.6, and have been approved to provide services to TRICARE beneficiaries and receive payment from TRICARE for services rendered to TRICARE beneficiaries.

Corporate services provider
A class of TRICARE-authorized individual professional providers that are employed directly or contractually by a corporation or foundation that provides principally professional services within the scope of the TRICARE benefit.

Network provider
A professional or institutional provider who has an agreement with UnitedHealthcare Military & Veterans to provide care at a contracted rate. A network provider agrees to file claims and handle other paperwork for TRICARE beneficiaries, and typically administers care to TRICARE Prime beneficiaries and those TRICARE Standard beneficiaries using TRICARE Extra (the preferred provider option). A network provider accepts the negotiated rate as payment in full for services rendered.

Non-network provider
A non-network provider does not have an agreement with UnitedHealthcare Military & Veterans, but is certified to provide care to TRICARE beneficiaries. There are two types of non-network providers: participating and nonparticipating.

1 Nonparticipating provider
A nonparticipating provider is a TRICARE-authorized hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to TRICARE beneficiaries but who does not have an agreement and does not accept the TRICARE allowable charge or file claims for TRICARE beneficiaries. A nonparticipating provider may only charge up to 15 percent above the TRICARE allowable charge.

2 Participating provider
A provider who has agreed to file claims for TRICARE beneficiaries, accept payment directly from TRICARE, and accept the TRICARE allowable charge as payment in full for services received. Non-network providers may participate on a claim-by-claim basis. Providers may seek payment of applicable copayments, cost-shares and deductibles from the beneficiary. Under the TRICARE outpatient prospective payment system, all hospitals that are Medicare-participating providers must, by law, also participate in TRICARE for inpatient and outpatient care.

Region
A geographic area determined by the federal government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

Right of first refusal (ROFR)
A MTF will review civilian prior authorizations and referrals received by UnitedHealthcare Military & Veterans to determine if the MTF is able to provide the requested services.

Split enrollment
Refers to multiple family members enrolled in TRICARE Prime under different TRICARE regions or MCSCs.
Sponsor
The sponsor is the ADSM or retiree through whom family members are eligible for TRICARE.

Supplemental Health Care Program (SHCP)
The SHCP is a program for eligible uniformed services members and other designated patients who require medical care that is not available at an MTF. Because services are not available at the MTF, these beneficiaries must be referred to a network provider.

Supplemental insurance
Supplemental insurance includes health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance plans, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

Transitional Assistance Management Program (TAMP)
A program that provides 180 days of transitional health care benefits to help certain uniformed services members (and their families) transition to civilian life.

Transitional care
Transitional care is a program that is designed for all beneficiaries to ensure a coordinated approach takes place across the continuum of care.

TRICARE allowable charge
The maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The TRICARE allowable charge is normally the lesser of: (a) the actual billed charge; (b) the CMAC or (c) the prevailing charge (or amount derived from a conversion factor) made for a given procedure, adjusted to reflect local economic conditions as detailed in the TRICARE Reimbursement Manual at manuals.tricare.osd.mil.

UB-04
The UB-04 form is used by hospitals and other institutional providers to bill government and commercial health plans; it must be used exclusively for institutional billing beginning Jan. 1, 2008. The UB-04 data set accommodates the NPI and incorporates a number of other important changes and improvements. It is also HIPAA-compliant.

Urgent Care Centers
Urgent care is medically necessary treatment that is required for an illness or injury that would not result in further disability or death if not treated immediately. The illness or injury does require professional attention and should be treated within 24 hours to avoid development of a situation in which further complications could result if treatment is not received.
Provider Forms
Samples of the Health Insurance Claim Form (Form 1500) and the Uniform Bill Form (UB-04) are illustrated on the following pages. To download the following forms, visit UHCMilitaryWest.com > Find a Form. These forms are current as of the publication of this Handbook. Updates may be made to these forms and their availability online.

General
- An Important Message from TRICARE
- Electronic Data Interchange Forms (Links to myTRICARE.com)
- Physician and Provider Demographic Change Submission Form
- Prescription Medical Necessity and Prior Authorization Forms
- TRICARE Beneficiary Liability Form–Waiver of Non-Covered Services Form
- Low Back Pain

Medical/Surgical Referral/Authorization
- An Important Message from TRICARE
- Electronic Data Interchange Forms (Links to myTRICARE.com)
- Low Back Pain
- Physician and Provider Demographic Change Submission Form
- Prescription Medical Necessity and Prior Authorization Forms
- Referral/Authorization Request Form
- TRICARE Beneficiary Liability Form–Waiver of Non-Covered Services Form

Behavioral Health
- Eating Disorder Precertification Checklist
- Inpatient Emergency Admission—Detox
- Inpatient Emergency Admission—Mental Health
- Outpatient Treatment Request
- Preauthorization for Electroconvulsive Therapy (ECT)
- Preauthorization for Inpatient Substance Abuse Rehabilitation
- Preauthorization for Partial Hospitalization
- Psychological and Neuropsychological Testing Request Form
- Residential Treatment Center (RTC) Application
- Waiver of Benefit Limit Request

Certification
- Provider Certification Forms (Links to myTRICARE.com > Provider Certification)

Clinical Programs
- Cancer Clinical Trial (CCT) Authorization Request
- Potential Quality Issue (PQI) Referral
Health Insurance Claim Form (Form 1500)  SAMPLE-Do not use

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPVA</th>
<th>GROUP HEALTH PLAN</th>
<th>FECA RETIRED/DEATH</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Medicare)</td>
<td>(Medicaid) (DeQD)</td>
<td>Member Only</td>
<td>Group Only</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT'S RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No., Street)
8. RESERVED FOR NUCU USE

CITY
STATE
ZIP CODE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
12. INSURED'S DATE OF BIRTH MM DD YY
13. WHEN CLAIM IS (Designated by NUCU)

14. INSURED'S NATIONAL ID NUMBER (Designated by NUCU)
15. IS THERE ANOTHER HEALTH BENEFIT PLAN
16. IS THERE ANOTHER HEALTH BENEFIT PLAN

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

17. INSURED'S POLICY GROUP OR FECA NUMBER
18. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
19. IS PATIENT'S CONDITION RELATED TO:

20. IS PATIENT'S CONDITION RELATED TO:

21. INSURED'S DATE OF BIRTH MM DD YY
22. PATIENT'S BIRTH DATE MM DD YY

23. INSURED'S BIRTH DATE MM DD YY

24. DATE OF SERVICE MM DD YY
25. DATE OF SERVICE MM DD YY

26. SERVICE DATE MM DD YY
27. SERVICE DATE MM DD YY

28. SERVICE DATE MM DD YY
29. SERVICE DATE MM DD YY

30. SERVICE DATE MM DD YY
31. SERVICE DATE MM DD YY

32. SERVICE DATE MM DD YY
33. SERVICE DATE MM DD YY

34. SERVICE DATE MM DD YY
35. SERVICE DATE MM DD YY

36. SERVICE DATE MM DD YY
37. SERVICE DATE MM DD YY

38. SERVICE DATE MM DD YY
39. SERVICE DATE MM DD YY

40. SERVICE DATE MM DD YY
41. SERVICE DATE MM DD YY

42. SERVICE DATE MM DD YY
43. SERVICE DATE MM DD YY

44. SERVICE DATE MM DD YY
45. SERVICE DATE MM DD YY

46. SERVICE DATE MM DD YY
47. SERVICE DATE MM DD YY

48. SERVICE DATE MM DD YY
49. SERVICE DATE MM DD YY

50. SERVICE DATE MM DD YY
51. SERVICE DATE MM DD YY

52. SERVICE DATE MM DD YY
53. SERVICE DATE MM DD YY

54. SERVICE DATE MM DD YY
55. SERVICE DATE MM DD YY

56. SERVICE DATE MM DD YY
57. SERVICE DATE MM DD YY

58. SERVICE DATE MM DD YY
59. SERVICE DATE MM DD YY

60. SERVICE DATE MM DD YY

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient’s signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient’s signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker’s compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 1 is completed, the patient’s signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient’s sponsor should be provided in those items captioned in “Insured”; i.e., Items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided all information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicaid and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral Law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered “incident to” a physician’s professional services, 1) they must be rendered under the physician’s direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician’s offices, and 4) the services of non-physicians must be included on the physician’s bills.

For TRICARE claims, I further certify that I (or any other employee) who rendered services is not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5535). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subjected to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1089; 5 USC 8101 et seq; and 30 USC 901 et seq, 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions which require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-17-0501, titled, ‘Carrier Medicare Claims Record,’ published in the Federal Register, Vol. 55 No. 177, page 37549, Wed, Sept. 12, 1990, or as updated and republished.


FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and Individual providers for the purposes relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment, Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the “Computer Matching and Privacy Protection Act of 1988,” permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State’s Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop CA-250-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.
FAQs for Completing the Form 1500

The 1500 claim form 02/12 version is now available from the National Uniform Claim Committee (NUCC) and includes two main changes: 1) a field to indicate whether ICD-9 or ICD-10 diagnosis codes are being reported; and 2) an increase in the number of diagnosis code fields from 4 to 12. It has been approved by the Centers for Medicare & Medicaid Services (CMS) to replace the 8/05 version.

Q1. What is the 1500 claim form?
A. The 1500 claim form is the standard paper claim form used by non-institutional providers or suppliers to bill payers for services and supplies.

Q2. Why has the form been revised?
A. The 1500 claim form 02/12 accommodates reporting for ICD-10 and aligns with CMS’ requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3.

Q3. What is the timeline for implementing the revised 1500 claim form?
A. UnitedHealthcare will follow the CMS timeline, which has also been adopted by the NUCC as the official timeline:
   - Jan. 6, 2014: Payers will begin receiving and processing paper claims submitted on the revised 1500 claim form.
   - Jan. six through March 31, 2014: Dual use period during which payers continue to receive and process paper claims submitted on the old 1500 Claim Form 08/05 version.
   - April 1, 2014: Payers receive and process paper claims submitted only on the revised 1500 claim form 02/12 version.

Q4. What are the changes on the revised 1500 claim form?
A. Following are changes to certain boxes on the revised 1500 claim form:

   - Header
   - Replaced 1500 rectangular symbol with black and white two-dimensional quick response (QR) code
   - Changed 08/05 to 02/12

   Box 1:
   - Changed “TRICARE CHAMPUS” to “TRICARE”
   - Replaced “SSN” with “ID#”

   Box 8:
   - Deleted “PATIENT STATUS” and content of field.
   - Changed title to “RESERVED FOR NUCC USE.”
Box 9b
• Deleted “OTHER INSURED’S DATE OF BIRTH, SEX.”
• Changed title to “RESERVED FOR NUCC USE.”

Box 9c
• Deleted “EMPLOYER’S NAME OR SCHOOL.”
• Changed title to “RESERVED FOR NUCC USE.”

Box 10d
• Changed title from “RESERVED FOR LOCAL USE” to “CLAIM CODES (Designated by NUCC).”

Box 11b
• Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “OTHER CLAIM ID (Designated by NUCC),”
• Added dotted line in the left-hand side of the field to accommodate a two-byte qualifier.

Box 14
• Changed title to “DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP).”
• Removed the arrow and text in the right-hand side of the field.
• Added “QUAL.” with a dotted line to accommodate a three-byte qualifier.

Box 15
• Changed title from “IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE” to “OTHER DATE.”
• Added “QUAL.” with two dotted lines to accommodate a three-byte qualifier.

Box 17
• Added a dotted line in the left-hand side of the field to accommodate a two-byte qualifier.

Box 19
• Changed title from “RESERVED FOR LOCAL USE” to “ADDITIONAL CLAIM INFORMATION (Designated by NUCC).”
Q5. When will the revised 1500 Claim Form 02/12 be printed?
A. CMS coordinated printing of the revised form with the Government Printing Office (GPO).
To receive copies of the 02/12 1500 contact:
• Your current forms supplier
• TFP Data Systems: 1500form@tfpdata.com This email address is being protected from spam bots. You need JavaScript enabled to view it. Or call 800-482-9367 ext. 58029.

Q6. Where can I find more information regarding the 1500 claim form?
A. For more information, please visit:
• nucc.org
• FAQs nucc.org/images/stories/PDF/1500_claim_form_faqs_2012_02.pdf
• cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html
Form 1500 Instructions

Claims must be submitted on the CMS-1500 for professional services. The following information is **required** on every claim:

**BOX 1** Indicate that this is a TRICARE claim by checking the box under “TRICARE.”

**BOX 1a** Sponsor’s Identification number or DoD Benefits Number. The sponsor is the person that qualifies the patient for TRICARE benefits.

**BOX 2** Patient’s name

**BOX 3** Patient’s date of birth and sex

**BOX 4** Sponsor’s full name. Do not complete if “self” is checked in BOX 6.

**BOX 5** Patient’s address including ZIP code. This must be a physical address. Post office boxes are not acceptable.

**BOX 6** Patient’s relationship to sponsor

**BOX 7** Sponsor’s address including ZIP code

**BOX 8** The NUCC recommends that this field not be used.

**Note:** Box 11d should be completed prior to determining the need for completing Boxes 9a–9d. If Box 11d is checked “Yes,” Boxes 9a and 9d must be completed. Additionally, if there is another insurance carrier, the mailing address of that insurance carrier must be attached to the claim form.

**BOX 9** Full name of person with other health insurance (OHI) that covers patient

**BOX 9a** Other insured’s policy or group number

**BOX 9b** The NUCC recommends that this field not be used.

**BOX 9c** The NUCC recommends that this field not be used.

**BOX 9d** Name of insurance plan or program name where individual has OHI

**BOX 10a–c** Check to indicate whether employment or accident related. (In the case of an auto accident, indicate the state where it occurred.)

**BOX 10d** When required, provide a sub-set of claim codes related to the patient’s condition.

**Note:** Box 11–Box 11c questions pertain to the sponsor.

**BOX 11** Indicate policy group or Federal Employees Compensation Act number (if applicable).

**BOX 11a** Sponsor’s date of birth and sex, if different than Box 3

**BOX 11b** Other claim ID

**BOX 11c** Indicate “TRICARE” in this field.

**BOX 11d** Indicate if there is another health insurance plan primary to TRICARE in this field.

**BOX 12** Patient’s or authorized person’s signature and date; release of information. A signature on file is acceptable provided signature is updated annually.

**BOX 13** Insured’s or authorized person’s signature. This authorizes payment to the physician or supplier.

**BOX 14** Date of current illness, injury, or pregnancy (LMP) (required for injury or pregnancy)

**BOX 15** First date patient (MM/DD/YY) had same or similar illness (not required, but preferred)

**BOX 16** Dates patient unable to work (not required, but preferred)

**BOX 17** Name of referring physician (very important to include this information)

**BOX 17a** Identification (non-NPI) number of referring physician with qualifier

**BOX 17b** Referring physician NPI
BOX 18 Admit and discharge date of hospitalization
BOX 19 Additional Claim Information (up to 83 characters).
BOX 20 Check if lab work was performed outside the physician’s office and indicate charges by the lab. If an outside provider (e.g., laboratory) performs a service, claims should include modifier “90” or indicate “Yes” in this block.
BOX 21 Indicate at least 1, and up to 12, specific diagnosis codes.
BOX 23 Prior authorization number
BOX 24A Date of service
BOX 24B Place of service
BOX 24C EMG (emergency) indicator
BOX 24D CPT/HCPCS procedure code with modifier, if applicable
BOX 24E Diagnosis code reference number (pointer)
BOX 24F Charges for listed service
BOX 24G Days or units for each line item
BOX 24H Early and Periodic Screening, Diagnosis, and Treatment related services/Family planning response and appropriate reason code (if applicable)
BOX 24I Qualifier identifying if the number is a non-NPI ID
BOX 24J Rendering Provider ID number. Enter the non-NPI ID number in the shaded area. Enter the NPI number in the unshaded area.
BOX 25 Physician’s/Supplier’s Tax ID Number
BOX 26 Patient’s account number (not required, but preferred)
BOX 27 Indicate whether provider accepts TRICARE assignment.
BOX 28 Total charges submitted on claim
BOX 29 Amount paid by patient or other carrier
BOX 31 Authorized signature
BOX 32 Name and address where services were rendered. This must be the actual physical location. If you use an independent billing service, please do not use the billing service’s address.
BOX 32a NPI of the service facility location
BOX 32b Two-digit qualifier identifying the non-NPI number followed by the ID number (if necessary)
BOX 33 Physician’s/supplier’s billing name, address, ZIP code, and phone number
BOX 33a NPI of billing provider
BOX 33b Two-digit qualifier identifying the non-NPI number followed by the ID number (if necessary)
## Form 1500 Place of Service Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>15</td>
<td>Mobile unit</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency room—hospital</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory surgical center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing center</td>
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<tr>
<td>26</td>
<td>Military treatment facility</td>
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<tr>
<td>31</td>
<td>Skilled nursing facility</td>
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<tr>
<td>32</td>
<td>Nursing facility</td>
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<td>33</td>
<td>Custodial care facility</td>
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<td>34</td>
<td>Hospice</td>
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<tr>
<td>41</td>
<td>Ambulance, land</td>
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<tr>
<td>42</td>
<td>Ambulance, air or water</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient psychiatric facility</td>
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<tr>
<td>52</td>
<td>Psychiatric facility, partial hospitalization</td>
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<tr>
<td>53</td>
<td>Community mental health center</td>
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<tr>
<td>54</td>
<td>Intermediate care center/mentally retarded</td>
</tr>
<tr>
<td>55</td>
<td>Residential substance abuse treatment facility</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric residential treatment center</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive inpatient rehabilitation facility</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive outpatient rehabilitation facility</td>
</tr>
<tr>
<td>65</td>
<td>End-stage renal disease treatment facility</td>
</tr>
<tr>
<td>71</td>
<td>State or local public health clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural health clinic</td>
</tr>
<tr>
<td>81</td>
<td>Independent laboratory</td>
</tr>
<tr>
<td>99</td>
<td>Other unlisted facility</td>
</tr>
</tbody>
</table>
UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured/beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or patient’s legal representative.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician’s certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient’s need for services are on file.

5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.

6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient’s signature on the provider’s request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.

9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter’s knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient’s parent or guardian has responded directly to the provider’s request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary’s cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS
Uniform Bill Form (UB-04) Instructions
The following listing of UB-04 form locators is a summary of the form locator (FL) information.

FL 1  Provider name, physical address and telephone number required
FL 2  Pay-to name and address required
FL 3a Patient control number
FL 3b Medical/health record number
FL 4  Type of bill (3-character alphanumeric identifier)
FL 5  Federal Tax Identification (ID) number
FL 6  Statement covers period (from - through). The beginning and ending dates of the period included on the bill are shown in numeric fields (MM-DD-YY).
FL 7  Not required
FL 8a-b Patient’s name (surname first, first name, and middle initial, if any). Enter the patient’s Social Security number (SSN) or DoD Benefits Number (DBN) in field “a.” Enter the patient’s name in field “b.”
FL 9a-e Patient’s address including ZIP code. This must be a physical address. Post office boxes are not acceptable.
FL 10 Patient’s birth date (MM-DD-YYYY). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.
FL 11 Patient’s sex. This item is used in conjunction with FLs 66–69 (diagnoses) and FL 74 a–e (surgical procedures) to identify inconsistencies.
FL 12 Admission date
FL 13 Admission hour
FL 14 Type of admission. This code indicates priority of the admission.
FL 15 Source of admission. This code indicates the source of admission or outpatient registration.
FL 16 Discharge hour
FL 17 Patient status. This code indicates the patient’s status as of the “Through” date of the billing period (FL 6).
FLs 18–28 Condition codes
FL 29 Accident state
FL 30 Not required
FLs 31–34 Occurrence codes and dates
FLs 35–36 Occurrence span code and dates
FL 37 Not required
FL 38 Responsible party name and address
FLs 39–41 Value codes and amounts
FL 42 Revenue code
FL 43 Revenue description—A narrative description or standard abbreviation for each revenue code in FL 42. Descriptions or abbreviations correspond to the revenue codes.
FL 44 HCPCS/rates. When coding HCPCS, enter the HCPCS code describing the procedure. May be required for correct reimbursement.
FL 45 Service date. If submitting claims for outpatient services, report a separate date for each day of service.
FL 46 Service units. The entries in this column quantify services by revenue category (e.g., number of days, a particular type of accommodation, pints of blood). Up to seven digits may be entered.

FL 47 Total charges

FL 48 Non-covered charges. The total non-covered charges pertaining to the related revenue code in FL 42 is entered here.

FL 49 Not required

FLs 50A–C Payer identification. Enter the primary payer on line A.

FLs 51A–C Health plan ID number

FLs 52A–C Release of information. A “Y” code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An “R” code indicates the release is limited or restricted. An “N” code indicates no release on file.

FLs 53A–C Assignment of benefits certification indicator

FLs 54A–C Prior payments. For all services other than inpatient hospital and skilled nursing facility (SNF) services, the sum of any amount(s) collected by the provider from the patient toward deductibles and/or co-insurance are entered on the patient (last) line of this column.

FLs 55A–C Not required

FL 56 National Provider Identifier (NPI). Beginning May 23, 2008, NPI number is required.

FLs 57A–C Other provider identifier number

FLs 58A–C Insured’s name

FLs 59A–C Patient’s relationship to insured

FLs 60A–C Insured unique ID/SSN/DBN/health insurance claim/ID number

FLs 61A–C Group name. Indicate the name of the insurance group or plan.

FLs 62A–C Insurance group number

FLs 63A–C Treatment authorization code. Contractor-specific or Home Health Agency Prospective Payment System (PPS) OASIS code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient preadmission or preprocedure, the authorization number is required for all approved admissions or services.

FLs 64A–C Document Control Number (DCN). Original DCN number of the claim to be adjusted.

FLs 65A–C Employer name. Name of the employer that provides health care coverage for the individual identified on FL 58.

FLs 66 Diagnosis and procedure code qualifier (ICD Version Indicator)

FLs 67 Principal diagnosis code. CMS only accepts ICD-9-CM diagnostic and procedural codes that use definitions contained in Department of Health and Human Services (HHS) Publication Number (PHS) 89-1260 or CMS-approved errata supplements to this publication. Diagnosis codes must be full ICD-9-CM diagnosis codes, including all five digits where applicable. For dates of service on or after transition to ICD-10, use the relevant ICD-10-CM diagnosis or ICD-10-PCS procedure code. Diagnosis codes must be full ICD-10-CM diagnosis codes, including all seven digits where applicable.

FLs 67A–Q Other diagnosis codes

FL 68 Not required
Admitting diagnosis. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient’s hospital admission.

Patient’s reason for visit

Prospective payment system (PPS) code

External cause of injury (ECI) code

Not required

Principal procedure code and date. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.

Other procedure codes and dates. The date of each procedure is shown in the date portion of Item 74, as applicable (MM-DD-YY). For procedures with dates of service on or after transition to ICD-10, the full ICD-10-PCS procedure codes, including all seven digits, must be shown for up to five significant procedures other than the principal procedure.

Not required

Attending/referring physician ID

Operating physician name and identifiers

Other physician ID

Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Authorized signature of non-network providers.

Code field
**Condition Codes**

2  Condition is employment related  
3  Patient covered by insurance not reflected here  
06  End-stage renal disease (ESRD) patient in first 30 months of entitlement covered by employer group health insurance  
08  Beneficiary would not provide information concerning other insurance coverage  
18  Maiden name retained  
19  Child retains mother’s name  
31  Patient is student (full time—day)  
33  Patient is student (full time—night)  
34  Patient is student (part time)  
36  General care patient in a special unit  
38  Semiprivate room not available  
39  Private room medically necessary  
40  Same-day transfer  
41  Partial hospitalization  
46  Nonavailability statement on file  
48  Psychiatric residential treatment centers for children and adolescents  
55  SNF bed not available  
56  Medical appropriateness  
60  Day outlier  
61  Cost outlier  
67  Beneficiary elects not to use lifetime reserve days  
A0  TRICARE External Partnership Program  
A2  Physically Handicapped Children’s Program  
C1  Approved as billed  
C2  Automatic approval as billed based on focused review  
C3  Partial approval  
C4  Admission/services denied  
C5  Post-payment review applicable  
C6  Admission pre-authorization  
C7  Extended authorization  
G0  Distinct medical visit (OPPS)

**Occurrence Span Codes**

1  Auto accident  
2  No-fault insurance involved—including auto accident/other  
3  Accident/tort liability  
4  Accident/employment related  
5  Accident/no medical or liability coverage  
6  Crime victim  
21  Date UR notice received  
22  Date active care ended  
24  Date insurance denied  
25  Date benefits terminated by primary payer  
26  Date SNF bed became available  
27  Date of hospice certification or recertification  
28  Date comprehensive outpatient rehabilitation plan established or last reviewed  
29  Date outpatient physical therapy plan established or last reviewed  
30  Date outpatient speech pathology plan established or last reviewed  
31  Date beneficiary notified of intent to bill (accommodations)  
32  Date beneficiary notified of intent to bill (procedures or treatments)  
33  First day of the Medicare Coordination Period for ESRD beneficiaries covered by Employer Group Health Plan (EGHP)

**Value Codes and Amounts**

1  Most common semiprivate rate  
2  Hospital has no semiprivate rooms  
05  Professional component included in charges and also billed separate to carrier  
30  Preadmission testing  
31  Patient liability amount  
37  Pints of blood furnished  
46  Number of grace days
## Frequently Used Addresses and Phone Numbers

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Military &amp; Veterans</td>
<td>TRICARE West Region Contractor Effective April 1, 2013. 7:00 a.m. to 7:00 p.m. local time, M-F</td>
<td>Phone: 877-988-9378&lt;br&gt;Online: UHCMilitaryWest.com</td>
</tr>
<tr>
<td>Allowable charges</td>
<td>View and download TRICARE-allowable charge rates</td>
<td>Online: tricare.mil/cmac&lt;br&gt;Online: myTRICARE.com&lt;br&gt;Online: UHCMilitaryWest.com</td>
</tr>
<tr>
<td>Authorizations and Referrals</td>
<td>Check referral and prior authorization requests status.</td>
<td>Phone: 877-988-9378&lt;br&gt;Fax Non-urgent: 877-890-8203&lt;br&gt;Fax Urgent: 877-890-9309&lt;br&gt;Fax Hospice: 877-890-8203&lt;br&gt;Fax Autism Services: 877-890-8156&lt;br&gt;Online: UHCMilitaryWest.com</td>
</tr>
<tr>
<td>Behavioral Health Care</td>
<td>For information about behavioral health benefits, patient eligibility verification, authorizations, and claims</td>
<td>Phone: 877-988-9378&lt;br&gt;Fax: 877-581-1590</td>
</tr>
<tr>
<td>Case Management</td>
<td>For UnitedHealthcare Military &amp; Veterans</td>
<td>Phone: 855-844-6800</td>
</tr>
<tr>
<td>Case Management (ECHO)</td>
<td>For participants enrolled in the ECHO program.</td>
<td>Phone: 866-480-0070&lt;br&gt;Fax: 877-890-8156</td>
</tr>
<tr>
<td>Case Management (SHCP)</td>
<td>For participants in the Supplemental Health Care Management program</td>
<td>Phone: 888-571-5232</td>
</tr>
<tr>
<td>Cancer Clinical Trials Coordinator</td>
<td>For UnitedHealthcare Military &amp; Veterans</td>
<td>Phone: 888-899-4933&lt;br&gt;Online: cancer.gov</td>
</tr>
<tr>
<td>Claims (PGBA)</td>
<td>Contact the West Region claims processor, PGBA, LLC, for assistance.</td>
<td>Inquiries &amp; Status: 877-988-9378&lt;br&gt;EDI Claims: 800-325-6920, Option 2&lt;br&gt;Online: myTRICARE.com</td>
</tr>
<tr>
<td>Continued Health Care Benefit Program (CHCBP)</td>
<td>For inquiries, authorizations and referrals and claims inquiries, contact Humana-Military.</td>
<td>Phone: 800-444-5445&lt;br&gt;Fax: 877-270-9113&lt;br&gt;Online: Humana-military.com</td>
</tr>
<tr>
<td>DEERS</td>
<td>Defense Enrollment Eligibility Reporting System (Beneficiaries only)</td>
<td>Phone: 800-538-9552</td>
</tr>
<tr>
<td>Dental: Delta Dental</td>
<td>TRDP: For military retirees only</td>
<td>Phone: 888-838-8737&lt;br&gt;Online: trdp.org or tricare.mil/dental</td>
</tr>
<tr>
<td>Dental: Metropolitan Life Insurance Company</td>
<td>TDP: ADFMs, National Guard and Reserve Members, and Individual Ready Reserve.</td>
<td>Phone: 855-638-8371&lt;br&gt;Online: tricare dental program.com</td>
</tr>
<tr>
<td>Dental: United Concordia Companies</td>
<td>ADDP: For active duty family members who cannot be seen at an MTF.</td>
<td>Phone: 866-984-ADDP (2337)&lt;br&gt;Online: adp ucci.com tricare.mil/dental</td>
</tr>
<tr>
<td>ECHO</td>
<td>Information and referrals</td>
<td>Phone: 855-874-6800&lt;br&gt;Fax: 877-890-8156&lt;br&gt;Online: militaryonesource.mil/efmp</td>
</tr>
<tr>
<td>Fraud and Abuse</td>
<td>Anonymously report suspected fraud and abuse</td>
<td>Phone: 888-899-5071</td>
</tr>
<tr>
<td>Hospice</td>
<td>The hospice benefit is designed to provide palliative care to individuals with prognoses of less than six months to live</td>
<td>Authorization Fax: 877-890-8203&lt;br&gt;Patient hospice election form fax: 877-890-9309</td>
</tr>
<tr>
<td>Inpatient Admission Notifications</td>
<td>Medical/surgical admission and maternity notifications</td>
<td>Fax: 877-578-2738</td>
</tr>
<tr>
<td>KEPRO</td>
<td>To attain TRICARE Certification</td>
<td>Phone: 888-841-6413&lt;br&gt;Online: <a href="mailto:TRICARE@kepro.com">TRICARE@kepro.com</a>&lt;br&gt;Mail: Attn: TRICARE Operations 777 East Park Drive Harrisburg, PA 17111</td>
</tr>
<tr>
<td>Resource</td>
<td>Description</td>
<td>Contact Information</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Provider Information Updates**             | Contact PGBA for assistance with provider certification and provider information updates.                                                                                                                                                                                                                                               | Phone: 877-988-9378  
Fax PGBA: 855-831-7044  
Online: myTRICARE.com                                                                                                                                                                                                                                                   |
| **Pharmacy Services: Express Scripts, Inc. (Express Scripts)** | Contact the TRICARE Pharmacy Program contractor, Express Scripts, Inc., for assistance with pharmacy benefits, claims, prior authorization, and other services and requirements.                                                                                                                                                                            | Phone: 877-363-1303  
Fax: 877-895-1900  
Online: express-scripts.com/tricare  
Mail: Express Scripts, Inc.  
P.O. Box 52150  
Phoenix, AZ 85072                                                                                                                                         |
| **Member Choice Center (MCC)**               | To assist beneficiaries with transferring their retail pharmacy prescriptions to home delivery.                                                                                                                                                                                                                                                  | Phone: 877-363-1433  
Online: tricare.mil/pharmacy  
Or: express-scripts.com/tricare                                                                                                                                                                                                                                                  |
| **National Provider Identifier (NPI)**       | Information and attaining an NPI                                                                                                                                                                                                                                                                                                               | Phone: 800-465-3203  
Mail: NPI Enumerator  
P.O. Box 6059  
Fargo, ND 58108-6059  
Online: tricare.mil/tma/hipaa/identifiers                                                                                                                                                                                                                                 |
| **Reserve and Service Member Support Office – Great Lakes (R&SMSO-GL)** | Contact the R&SMSO-GL for assistance regarding health care for active duty Army, Navy, Air Force, Marine Corps, Coast Guard, and certain TRICARE-eligible National Guard and Reserve members                                                                                                                                                        | Phone: 888-647-6676  
Online: tricare.mil/mmsso  
Mail: R&SMSO-GL  
P.O. Box 886999  
Great Lakes, IL 60088-6999                                                                                                                                                                                                                                                 |
| **TRICARE For Life (TFL)**                   | Contact the TFL administrator, Wisconsin Physicians Service (WPS)/TFL, for assistance with TFL benefits, claims, and requirements.                                                                                                                                                                                                            | Phone: 866-773-0404  
TDD: 866-773-0405  
Online: TRICARE4u.com  
Mail: WPS/TRICARE For Life  
P.O. Box 7889  
Madison, WI 53707-7889  
(general correspondence only, no claims)                                                                                                                                                                                                                                 |
| **TRICARE North Region**                     | For claims inquiries regarding beneficiaries with a residential address in the North Region contact HealthNet.                                                                                                                                                                                                                                  | Phone: 877-874-2273  
Online: hnfds.com                                                                                                                                                                                                                                                                                                                             |
| **TRICARE South Region**                     | For claims inquiries regarding beneficiaries with a residential address in the South Region contact Humana-military.                                                                                                                                                                                                                         | Phone: 800-403-3950  
Online: humana-military.com                                                                                                                                                                                                                                                                                                                   |
| **U.S. Public Health Service (USPHS)**       | Obtain assistance regarding health care for USPHS personnel.                                                                                                                                                                                                                                                                                   | Phone: 800-368-2777, option 2                                                                                                                                                                                                                                                                                                                  |
# Liability Insurance Requirements Tables

## TRICARE West Professional

<table>
<thead>
<tr>
<th>State</th>
<th>UHG Recommended Professional Liability Limits</th>
<th>UHG Minimum Professional Liability Limits</th>
<th>Minimum General Liability Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Standard in States with No Specified Liability Limits - Low Risk Providers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska, Arizona, California, Hawaii, Idaho, Iowa, Minnesota, Montana, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington</td>
<td>$1,000,000 each claim/ $3,000,000 aggregate</td>
<td>$500,000 each claim/ $1,000,000 aggregate</td>
<td>$1,000,000 per occurrence</td>
</tr>
<tr>
<td><strong>UHG Preferred Standard in States with No Specified Liability Limits - High Risk Providers (OB/GYN, Surgeons, Anesthesiologists)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska, Arizona, California, Hawaii, Idaho, Iowa, Minnesota, Montana, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington</td>
<td>$5,000,000 each claim/ $5,000,000 aggregate</td>
<td>$1,000,000 each claim/ $3,000,000 aggregate</td>
<td>$1,000,000 per occurrence</td>
</tr>
<tr>
<td><strong>States with Specified Liability Limits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>$1,000,000 each claim/ $3,000,000 aggregate</td>
<td>State minimum</td>
<td>$1,000,000 per occurrence</td>
</tr>
<tr>
<td>Missouri</td>
<td>500,000 each claim/aggregate*</td>
<td></td>
<td>$1,000,000 per occurrence</td>
</tr>
<tr>
<td><strong>Patient Compensation Fund States - Mandatory</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>$200,000 each claim/$600,000 aggregate</td>
<td></td>
<td>$1,000,000 per occurrence</td>
</tr>
<tr>
<td><strong>Patient Compensation Fund States - Voluntary</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>$500,000 each claim/$1,000,000 aggregate</td>
<td></td>
<td>$1,000,000 per occurrence</td>
</tr>
<tr>
<td>New Mexico</td>
<td>$200,000 per occurrence</td>
<td></td>
<td>$1,000,000 per occurrence</td>
</tr>
<tr>
<td>Wyoming</td>
<td>$1,000,000 each claim/aggregate</td>
<td></td>
<td>$1,000,000 per occurrence</td>
</tr>
<tr>
<td><strong>Standard Limits Procured in the State</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>$200,000 each claim/$600,000 aggregate</td>
<td></td>
<td>$1,000,000 per occurrence</td>
</tr>
</tbody>
</table>

## TRICARE West Facilities

<table>
<thead>
<tr>
<th>State</th>
<th>UHG Recommended Professional Liability Limits</th>
<th>UHG Minimum Professional Liability Limits</th>
<th>Minimum General Liability Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Professional and General Liability Limits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming</td>
<td>$1,000,000 each claim/ $3,000,000 aggregate</td>
<td>$500,000 each claim/ $1,000,000 aggregate</td>
<td>$1,000,000 per occurrence</td>
</tr>
<tr>
<td>Texas</td>
<td>$1,000,000 each claim/ $3,000,000 aggregate</td>
<td>$100,000 each claim/ $3,000,000 aggregate</td>
<td>$100,000 per occurrence</td>
</tr>
</tbody>
</table>

## TRICARE West Ancillary

<table>
<thead>
<tr>
<th>State</th>
<th>UHG Recommended Professional Liability Limits</th>
<th>UHG Minimum Professional Liability Limits</th>
<th>Minimum General Liability Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Specified Professional and General Liability Limits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming</td>
<td>$1,000,000 each claim/ $3,000,000 aggregate</td>
<td>$500,000 each claim/ $1,000,000 aggregate</td>
<td>$1,000,000 per occurrence</td>
</tr>
<tr>
<td>Texas</td>
<td>$1,000,000 each claim/ $3,000,000 aggregate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1,000,000 each claim/ $3,000,000 aggregate</td>
<td></td>
</tr>
</tbody>
</table>

*Hospital staff located in a county with a population greater than 75,000*