TRICARE Provider Handbook

Your guide to TRICARE programs, policies, and procedures

TRICARE West

TRICARE Provider Handbook—West Region

An Important Note About TRICARE Program Changes

The "TRICARE Provider Handbook" will assist you in delivering TRICARE benefits and services. At the time of printing, the information in this handbook is current. It is important to remember that TRICARE policies and benefits are governed by public law. Changes to TRICARE programs are continuous, and new benefits are added regularly as we continue to make TRICARE a better program. For the most recent information, contact TriWest Healthcare Alliance at 1-888-TRIWEST (1-888-874-9378) or visit www.triwest.com. More information regarding TRICARE can also be found online at www.tricare.osd.mil or by visiting your local TRICARE Service Center.

Using This TRICARE Provider Handbook

This TRICARE Provider Handbook has been developed to provide you and your staff with basic, important information about TRICARE while emphasizing key operational aspects of the program and program options. The information contained in this handbook will assist you in coordinating care for TRICARE beneficiaries and contains accurate, updated information about specific TRICARE programs, policies, and procedures.

The TRICARE Provider Handbook may be modified periodically through quarterly TRICARE Provider Newsletters and/or monthly Provider Bulletins. Additionally, the handbook will be updated annually or as needed. Change pages will be provided to your staff when information in the handbook changes. If you or your staff receives change pages for the handbook, please insert them into your handbook immediately so that you will continue to have the most up to date information about TRICARE at your fingertips. The handbook is available electronically on the TRICARE Provider Web site at www.tricare.osd.mil/provider. You may request a new or additional TRICARE Provider Handbook from TriWest Healthcare Alliance at 1-888-TRIWEST (1-888-874-9378).

Thank you for your service to America's heroes and their families. For assistance, network providers should contact their local network representative (see the chart in the section entitled, "Welcome to TRICARE and the West Region"). Non-network providers should contact the local TRICARE field representative at 1-888-TRIWEST (1-888-874-9378).

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An introduction to your TRICARE provider contractor, network subcontractors, and vendors

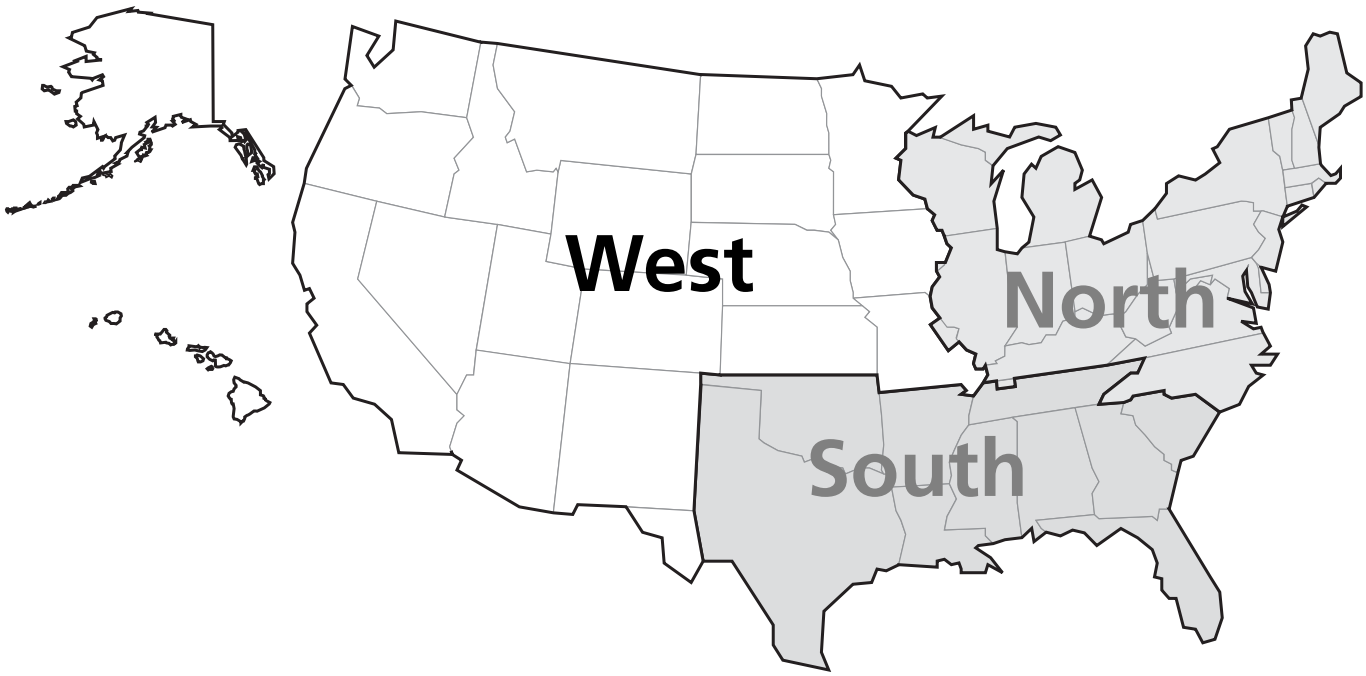
Welcome to TRICARE and the West Region

What Is TRICARE?

TRICARE is the health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE's primary objectives are to optimize the delivery of health care services in the military's direct care system for all Military Health System (MHS) beneficiaries and attain the highest level of patient satisfaction through the delivery of a world-class health care benefit. TRICARE brings together the health care resources of the Army, Navy, and Air Force and supplements them with networks of civilian health care professionals to provide better access and high quality health care services while maintaining the capability to support military operations.

TRICARE is available worldwide and managed regionally in six separate TRICARE regions—TRICARE North, TRICARE South, TRICARE West, TRICARE Europe, TRICARE Pacific, and TRICARE Latin America/Canada—jointly by the TRICARE Management Activity (TMA) and TRICARE Regional Offices. TMA has partnered with civilian managed care support contractors (MCSCs) in the North, South, and West Regions to assist TRICARE Regional Directors and military treatment facility (MTF) commanders in operating an integrated health care delivery system.

TRICARE Regions



Your Managed Care Support Contractor

TriWest Healthcare Alliance is DoD's partner to assist in operating the TRICARE program for more than 2.6 million TRICARE-eligible beneficiaries in the 21-state TRICARE West Region. The West Region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (except the Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner, including El Paso only), Utah, Washington, and Wyoming.

TriWest is committed to preserving the integrity, flexibility, and durability of the MHS by offering beneficiaries access to the finest health care services available, thereby contributing to the continued superiority of U.S. combat readiness. To help ensure that beneficiaries in the TRICARE West Region receive quality health care, TriWest has subcontracted with local health plans referred to as network subcontractors.

TriWest's Network Subcontractors and Vendors

In an effort to provide local representation and expertise, TriWest has subcontracted the network development and maintenance activities to each of its network subcontractors. These subcontractors work with TriWest and network (contracted) providers to provide access to care for beneficiaries in the West Region. The West Region's network subcontractors include:

- Blue Cross and Blue Shield of Arizona, Inc.
- Blue Shield of California
- University of Colorado Hospital Authority
- Hawaii Medical Service Association
- Regence Blue Shield of Idaho
- Wellmark, Inc., Iowa and South Dakota
- Blue Cross and Blue Shield of Kansas, Inc.
- Blue Cross and Blue Shield of Kansas City
- Blue Cross and Blue Shield of Montana, Inc.
- Blue Cross and Blue Shield of Nebraska
- University of New Mexico Hospital
- Blue Cross and Blue Shield of North Dakota
- Regence Blue Cross Blue Shield of Oregon
- Blue Cross and Blue Shield of Texas
- Regence Blue Cross Blue Shield of Utah
- Regence Blue Shield of Washington
- Blue Cross Blue Shield of Wyoming
- TriWest Healthcare Alliance (for Minnesota, Missouri, and Nevada)

Each network subcontractor has designated an individual to be the first point of contact for communicating with network providers in the state. This individual—the network representative—is responsible for developing, educating, maintaining, and assisting the local TRICARE network of providers.

See Local Network Representatives matrix later in this section.

Spectrum Healthcare Resources

Spectrum Healthcare Resources is subcontracted to manage resource sharing and support services within the TRICARE West Region. Resource sharing is a key component in staffing local MTFs. Internal resource sharing agreements facilitate the placement of civilian medical personnel into MTFs to enhance the facility's ability to provide medical services to TRICARE beneficiaries.

Wisconsin Physicians Service

Wisconsin Physicians Service (WPS) is TriWest's partner for claims processing. WPS has 48 years of experience with every aspect of claims processing activities and is the premier organization for the development of electronic claims submission options. Please see the section entitled "Claims Processing and Billing Information" for specific options and instructions for filing claims electronically. Virtually all providers will be able to file claims electronically, thus shortening the reimbursement time and enhancing the accuracy of claims submission. Online assistance will be available at the time of claims submission.

Local Network Representatives		
State	Network Representative	Phone
Alaska*	Kathie Adams (for contracting only)	907-743-1809
Arizona	Blue Cross and Blue Shield of Arizona, Inc.	602-864-4231
California	Blue Shield of California	866-296-8744
Colorado	University of Colorado Hospital Authority	303-372-2884 303-372-2354 303-372-2321
Hawaii	Hawaii Medical Service Association	808-948-5213 / 5195
Idaho	Regence Blue Shield of Idaho	866-731-1330
Iowa	Wellmark, Inc.	712-279-8427
Kansas	Blue Cross and Blue Shield of Kansas, Inc.	785-291-7507
Kansas City, Mo.	Blue Cross and Blue Shield of Kansas City (Professional & Ancillary Providers) (Institutional Providers)	 816-395-3946 816-395-3544
Minnesota	TriWest Healthcare Alliance	612-338-2279
Missouri (excluding Kansas City)	TriWest Healthcare Alliance	573-329-8630
Montana	Blue Cross and Blue Shield of Montana	406-444-8273
Nebraska	Blue Cross and Blue Shield of Nebraska	402-343-3517
Nevada	TriWest Healthcare Alliance	702-450-4001
New Mexico	University of New Mexico Hospital	505-272-2469
North Dakota	Blue Cross and Blue Shield of North Dakota	701-282-1401
Oregon	Regence Blue Cross Blue Shield of Oregon	800-547-0939
South Dakota	Wellmark, Inc.	712-279-8427
Texas (El Paso)	Blue Cross and Blue Shield of Texas	915-496-6600
Utah	Regence Blue Cross Blue Shield of Utah	801-333-2610
Washington	Regence Blue Shield of Washington	800-562-2156
Wyoming	Blue Cross Blue Shield of Wyoming	307-432-2866

Note: A local TriWest representative is the Network Representative for TRICARE network providers in Minnesota, Missouri, and Nevada. Non-network providers with questions should contact a TRICARE field representative at 1-888-TRIWEST (1-888-874-9378).

**In the state of Alaska, TriWest will assist the TRICARE Alaska Office (TAO) with educational services. Contracting will be administered by the TAO in that state.*

Provider Resources

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

TRICARE Web Site Provider Portal www.tricare.osd.mil/provider

A Provider Portal is available on the TRICARE Web site, and it provides national TRICARE information, including links to TRICARE regulatory guidance, policies, and procedures; TRICARE program options and features; and the latest news and events. It is the main resource for anything you need to know about TRICARE.

TRICARE Online www.tricareonline.com

TRICARE Online is a Department of Defense (DoD) Internet portal to interactive health care services and information accessible by all TRICARE beneficiaries. Each MTF has its own page on TRICARE Online and most MTF providers maintain an individual "Provider" page on the MTF site. Providers are encouraged to include a picture and specific clinical information about themselves on the page. Many have provided educational links from their page to health care information that they want to share with their patients.

TriWest Healthcare Alliance Web Site www.triwest.com

TriWest has developed a portal especially for its providers. The portal makes it easy for providers to create their own account to:

- Submit claims online
- Find a network specialty provider
- Request printed TRICARE information
- View the TRICARE Provider Handbook, newsletters, and bulletins online
- View patient benefit information
- View assigned patients

TriWest's Interactive Voice Response System 1-888-TRIWEST (1-888-874-9378)

TriWest offers an interactive voice response (IVR) system to assist providers with routine questions through self-service over the phone. The IVR system utilizes natural speech recognition to understand words, numbers, and phrases. Follow the simple greeting and prompts to get quick information and accurate answers on many topics, such as verifying beneficiary eligibility, checking the status of claims, and reviewing the status of authorization requests.

Here are some quick tips for using the TriWest IVR System:

- Call 1-888-TRIWEST (1-888-874-9378) any time
- Say "Provider" to access the health care provider menu*
- To speak directly to a customer service representative, say "Help" or "Customer Service"*
- Return to the main menu at any time by saying "Main Menu"
- End the call by saying "Good-bye"

**As you become more familiar with the IVR, you can bypass the greetings by stating the subject you are interested in. For example, by saying "Provider" then "Claims," you will go directly to the claims menu.*

TriWest Hubs

TriWest has established "hubs" throughout the TRICARE West Region, which are staffed with clinical personnel. Hub staff work with providers by reviewing and responding to all referral or authorization requests. When first-level reviewers cannot approve the referral or authorization request, the request is referred to a second-level, peer reviewer. As a provider, all you need to do is call 1-888-TRIWEST (1-888-874-9378) and the call will be routed to the appropriate TriWest Hub.

Policies, procedures, and guidance for TRICARE providers

Important Provider Information

TRICARE Policy

Provisions of the U.S. Constitution authorize Congress to make laws by passing an "Act" (e.g., Defense Appropriations Act of 1999). When an act is passed, it becomes a federal law, which generally supercedes any state law (unless it specifies that a state law may apply). An act can be codified in a number of statutes. These statutes are classified and coded in the United States Code. Title 10 of the United States Code houses all statutes regarding the armed forces.

When an act relevant to TRICARE becomes law, the Department of Defense (DoD) directs TriWest on the manner in which that law should be administered. This direction comes through modifications to federal regulations (e.g, the code of federal regulations (CFR), the TRICARE Operations Manual, TRICARE Reimbursement Manual, and the TRICARE Policy Manual). Depending on the complexity of the law, it can take a year or more before direction from the DoD is given and TriWest can begin administration of the new policy. For additional information, refer to the TRICARE manuals at www.tricare.osd.mil.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996, to combat waste, fraud, and abuse; improve portability of health insurance coverage; and simplify health care administration. All health plans, health care clearinghouses, and health care providers who conduct certain financial and administrative transactions electronically must comply with HIPAA. The TRICARE health plan, military treatment facilities (MTFs), providers, the TRICARE contractors, subcontractors, clearinghouses, and other business associates fall within these categories.

In compliance with the portability portion of the HIPAA, the Military Health System (MHS), through the Defense Manpower Data Center Support Office (DSO), issues Certificates of Creditable Coverage automatically to beneficiaries who lose TRICARE coverage.

Under the Administrative Simplification portion of the HIPAA, the Department of Health and Human Services (HHS) has published five rules for HIPAA compliance:

- Transactions and Code Sets Rule, published August 17, 2000. Compliance date: October 16, 2003.
- Privacy Rule, published December 28, 2000. Compliance date: April 14, 2003.
- Employer Identifier Rule, published May 31, 2002. Compliance date: July 30, 2004.
- Security Rule, published February 20, 2003. Compliance date: April 21, 2005.
- National Provider Identifier Rule, published January 23, 2004. Compliance date: May 23, 2007.

Effective April 14, 2003, the HIPAA Privacy Rule provisions were implemented nationwide and all covered entities, including providers, were required to be in full compliance with the Privacy Rule.

Effective October 16, 2003, HIPAA standard electronic transactions were implemented within the MHS.

Guidelines for Implementing the HIPAA Privacy Rule

As required by the HIPAA Privacy Rule, provider offices/groups must train all members of their workforces on the policies and procedures with respect to protected health information (PHI) as necessary to carry out their function. Appropriate safeguards must be in place that provide security to PHI from an administrative, technical, and physical standpoint. Providers must reasonably safeguard PHI from any intentional or unintentional use or disclosure that is in violation of the standards, implementation specifications, or other requirements of the standard.

Providers are permitted by the HIPAA Privacy Rule to make use and disclosure of an individual's PHI for purposes of treatment, payment, and health care operations. PHI is the information created and obtained as providers deliver services to beneficiaries. Such information may include documentation of symptoms, examination and test results, diagnoses, treatments, and applying for future care or treatment. It also includes billing documents for those services.

In addition, providers are permitted to use PHI for health care operations without being required to obtain a release or authorization for activities, such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance.

Disclosures that do not have to be included for the HIPAA Privacy Rule include:

- Releases for treatment, payment, or health care operations
- Releases to the individual
- Releases occurring with patient's written authorization
- Releases for the directory or other persons involved in the individual's care
- Releases to national security or intelligence agencies
- Releases to correctional institutions or law enforcement as provided in 164.512(k)(5)

HIPAA requires that all PHI be kept completely confidential. PHI is defined as information about individuals or beneficiaries which contains the following data:

- Home address
- Home telephone number
- Race
- Social security number
- Medical records
- Photographs
- Any information that may compromise the privacy of or prove harmful to the beneficiary

Some state laws contain more stringent requirements than those required by the federal regulation under HIPAA. Providers must be familiar with both federal and state regulations and comply with their requirements in their entirety.

To maintain confidentiality, HIPAA precludes TriWest and Wisconsin Physicians Service (WPS) employees from providing information to parents or guardians of minors, or persons who are unable to make health care decisions for themselves, when the services are related to alcoholism, abortion, drug abuse, venereal disease, or HIV.

Additional guidance about the release of patient information is found later in this section under "Provider Responsibilities."

Military Health System Notice of Privacy Practices

The MHS Notice of Privacy Practices informs beneficiaries how PHI may be used or disclosed. It describes safeguards in place to protect PHI and explains patient privacy rights. The notice has been published in nine languages, including braille, and an audio version is available for vision-impaired beneficiaries.

Privacy officers are located at every MTF. They serve as beneficiary advocates for privacy issues and will respond to inquiries from TRICARE beneficiaries regarding their PHI. Beneficiaries may contact their privacy officer if they have questions about the notice of privacy practice or about their privacy rights. Beneficiaries may also visit the TRICARE Web site at www.tricare.osd.mil/hipaa for more information about the notice of privacy practices or other HIPAA requirements. Specific questions about HIPAA may be sent via e-mail to hipaamail@tma.osd.mil.

If you or your staff would like copies of the MHS Notice of Privacy Practices, visit the TRICARE Web site at www.tricare.osd.mil or contact TriWest at 1-888-TRIWEST (1-888-874-9378).

HIPAA Transactions and Code Sets

The HIPAA Transactions and Code Sets Rule has mandated the use of electronic standards for certain administrative and financial health care transactions. Compliance with this rule was mandated for October 16, 2003. The table below lists the mandated HIPAA electronic transactions.

Transaction No.	Transaction Standard
X12N 270/271	Eligibility/Benefit Inquiry and Response
X12N 278	Referral Certification and Authorization
X12N 837	Claims: (Institutional, Professional, and Dental) and Coordination of Benefits (COB)
12N 276/277	Claim Status Request and Response
X12N 835	Payment and Remittance Advice
X12N 834	Enrollment/Disenrollment in a Health Plan
X12N 820	Payroll Deduction for Insurance Premiums
NCPDP Telecom Std. Ver. 5.1	Retail Pharmacy Drug Claims, COB, Referral Certification and Authorization, Eligibility Inquiry and Response
NCPDP Batch Std. Ver. 1.1	Retail Pharmacy Drug Claims, COB, Referral Certification and Authorization, Eligibility Inquiry and Response
TBD	Claims Attachments
TBD	First Report of Injury

The MHS and the TRICARE program are now HIPAA compliant with standard transactions and code sets. Where these business functions are performed electronically, the HIPAA standards are now in use. For more information, visit the TRICARE HIPAA Web site at www.tricare.osd.mil/hipaa.

HIPAA National Provider Identifier

The HIPAA National Provider Identifier (NPI) Final Rule, published in the Federal Register January 23, 2004, adopts the NPI as the standard unique identifier for health care providers. The rule becomes effective May 23, 2005, and the MHS and TRICARE must be compliant by May 23, 2007. All entities who meet the definition of "health care provider" are eligible for NPIs. However, providers who are "covered entities" are required to obtain and use NPIs.

Enumeration of the NPI will be through the National Provider System (NPS), which is being built under a contract for the Department of Health and Human Services (HHS). The NPS will be a central system for identifying and uniquely enumerating health care providers at the national level and will assign NPIs to health care providers. Enumeration can begin after the effective date of May 23, 2005.

The NPI is a 10-position, all-numeric identifier that is easily accommodated in all HIPAA standard electronic transactions. NPIs will not contain intelligence about the provider. For enumeration purposes, there will be two categories of health care providers. Entity Type Code 1 is for individuals, such as physicians, nurses, dentists, chiropractors, pharmacists, and physical therapists. Entity Type Code 2 is for organizations, such as hospitals, home health agencies, clinics, nursing homes, laboratories, and MTFs.

Over the course of the next year, TMA will be addressing requirements and policy issues related to enumerating providers and use of the NPI within the MHS.

HIPAA Employer Identifier

The National Employer Identifier Final Rule was published on May 31, 2002. Covered entities must be compliant with the rule by July 30, 2004. For HIPAA purposes, employers are defined as the sponsors of health insurance for their employees. The standard selected for the national employer identifier is the Employer Identification Number (EIN) as issued by the Internal Revenue Service (IRS). This number is

the EIN that appears on an employee's IRS Form W-2, Wage and Tax Statement, and is the number that will be used to identify that employer in standard electronic health care transactions. Covered health care providers, health plans, and health care clearinghouses must accept and transmit the EIN where required in electronic health transactions.

TRICARE Provider Types

TRICARE defines a provider as a person, business, or institution that provides or gives health care. For example, a doctor is a provider. A hospital is a provider. An ambulance company is a provider. There are many other types. A provider must be authorized under the TRICARE Regulation and must have their authorized status verified (certified) by TriWest Healthcare Alliance.

Please note that active duty service members and civilian employees of the Federal Government who are health care providers are generally not authorized to be TRICARE providers in civilian facilities. So, if a TRICARE beneficiary sees a provider in a civilian facility that they know works at an MTF, they should check to ensure that TRICARE will provide reimbursement. Below are some classifications of providers.

Authorized Providers

An authorized provider is a hospital or institutional provider, a physician or other individual professional provider, or other provider of services or supplies who meets the licensing and certification requirements of TRICARE in 32 CFR 199.6 and is practicing within the scope of that license. Any physician listed in the 32 CFR 199.6 who holds a valid license to practice medicine in the state where he/she practices shall be an authorized provider. Providers not specifically listed in 32 CFR 199.6 are not considered authorized providers unless they are included in a TRICARE demonstration project.

Certified Providers

A hospital or institutional provider, physician, or other individual professional provider of services or supplies specifically authorized by 32 CFR 199.6. Certified providers have been verified by TRICARE Management Activity (TMA) or TriWest to meet the standards of 32 CFR 199.6 and have been approved to provide services to TRICARE beneficiaries and receive government payment for services rendered to TRICARE beneficiaries.

Network Providers

A network provider is one who serves TRICARE beneficiaries through a contractual agreement with TriWest as a member of the TRICARE network or any other preferred provider network or by any other contractual agreement with TriWest. A network provider accepts the negotiated rate as payment in full for services rendered.

Non-network Providers

A non-network provider is one who has no contractual relationship with TriWest to provide care to TRICARE beneficiaries but is certified. Payment cannot be made to non-certified (unauthorized) providers. There are two types of non-network providers– "participating" and "nonparticipating."

Participating Providers

Providers who participate in TRICARE, also called "accepting assignment," agree to accept the TRICARE-determined allowable cost or charge as the total charge for services—also known as the TRICARE allowable charge—as the full fee for care. In the case of network providers, the negotiated rate is considered the TRICARE allowable charge. Non-network, individual providers may participate on a case-by-case basis. Providers may seek applicable copayments or cost-shares and deductibles from the beneficiary. Hospitals that participate in Medicare must, by law, also participate in TRICARE for inpatient care. For outpatient care, they may or may not participate.

Nonparticipating Providers

A nonparticipating provider is a certified hospital, institutional provider, physician, or other provider that furnishes medical services or supplies to TRICARE beneficiaries, but who has not signed a contract with TriWest and does not agree to "accept assignment." Any applicable payments are forwarded to the beneficiary.

Provider Certification and Credentialing

Certification

At a minimum, all TRICARE providers must be certified. Wisconsin Physicians Service (WPS), TriWest's claims processing subcontractor, conducts the certification process, which includes assigning a TRICARE identification number to the provider. Being TRICARE-certified allows accurate 1099 tax form reporting to the Internal Revenue Service. Providers are notified by WPS when the certification process has been completed. Providers who are certified only are considered non-network providers. To obtain a certification packet, call WPS at 1-888-TRIWEST (1-888-874-9378) or go to their web site, www.triwest.com and download the forms.

Credentialing

In addition to certification, the local network representative must credential a provider interested in signing a contract and becoming a member of the TRICARE network. The credentialing process involves obtaining primary source verification of the provider's education, license, professional background, malpractice history, and other pertinent data. Credentialing and contracting packets may be obtained from the local network representative who assists in completing the paperwork and executing the contract. See the list of local network representatives in the section entitled, "Welcome to TRICARE and the West Region," for the phone number to your local network representative. A provider who is certified, credentialed, and has signed a contract is considered to be a network provider.

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

Provider Responsibilities

When a provider signs a TRICARE contract, he/she agrees to adhere to all contract requirements. The following is a sample of the requirements detailed in the provider's contract:

- Provider shall 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 TriWest and TRICARE beneficiaries for covered services and for all services paid for by the TRICARE Program.
- Provider shall collect applicable copayments, cost-shares, or deductibles from TRICARE beneficiaries. Provider shall not require payment from a TRICARE beneficiary for any excluded or excludable service that the TRICARE beneficiary received unless the TRICARE beneficiary has been properly informed that the services are excludable and has agreed in advance of receiving the services, in writing, to pay for such services. Any waivers must be specific as to the details of the excluded or non-covered service.
- Provider shall submit all claims for covered services on behalf of TRICARE beneficiaries and active duty personnel. All claims will be submitted electronically.
- Provider shall participate in Medicare (accept assignment) and submit claims on behalf of all TRICARE and Medicare beneficiaries.
- Provider shall comply with all policies and procedures set forth in the TRICARE Provider Handbook, including without limitation credentialing, peer review, referrals, utilization review/management, and quality assurance programs and procedures established by TriWest or TRICARE, including submission of information concerning provider and compliance with pre-authorization requirements, authorizations, concurrent reviews, retrospective reviews, discharge planning for inpatient admissions, and prior authorization of referrals.
- If provider offers behavioral health services, and the TRICARE beneficiary authorizes release of the information, the provider shall submit to the TRICARE beneficiary's primary care manager (PCM) a copy of the record of the treatment provided.
- Provider or designee shall attend an initial educational seminar (and periodic update seminars) in order to obtain an understanding of the requirements of the TRICARE program.
- Provider agrees to furnish each TRICARE beneficiary with a copy of his/her medical record at no charge (to include a narrative summary and other documentation of care) within two business days of the request.

- Provider agrees to forward copies of medical records to TriWest within two business days of TriWest's request.
- Provider understands and agrees that all covered services provided to TRICARE Prime enrollees, except emergency services, must be referred from the PCM to a network provider or an MTF provider, and authorized by the applicable health care coordinator or other designee of TriWest.
- Provider acknowledges and understands that the MTF has a first right of refusal to provide medical services to TRICARE Prime beneficiaries who are referred for any services by their PCM.
- Provider shall comply with all final HIPAA ASC X 12N Transaction and Code Sets standards as promulgated by the Secretary, Department of Health and Human Services.
- Specialists and facilities will submit consultation reports, discharge summaries, and operative reports to the beneficiary's PCM within 10 working days. Specialists and facilities will receive a regular report listing all the TRICARE beneficiaries who have been referred for care and for whom a consultation report, operative report, or discharge summary, as applicable, has not been returned to the PCM within 10 working days. The specialist's or facility's office staff may then compare the list with his/her records and return the updated report to TriWest. TriWest will forward the updated report to the PCM for his/her review.

Office and Appointment Access Standards

By signing a TRICARE contract, network providers are obligated to adhere to all contract requirements.

One of the requirements is to meet all office and appointment access standards. Those standards are as follows:

- Normal business hours for primary care services will be from 9 a.m. to 5 p.m., Monday–Friday. TriWest encourages extended hours as a convenience to beneficiaries who work during these hours.
- Office wait times for nonemergencies may not exceed 30 minutes, unless emergency care is being rendered and the normal schedule is disrupted.
- If serving as a PCM, the provider must be available by telephone or by appointment 24 hours a day, seven days a week to help ensure timely evaluation of the beneficiary's health care needs. If the PCM is not available, the covering PCM is subject to TriWest's credentialing and peer-review procedures.
- Wait times for appointments for well and specialty visits may not exceed four weeks.
- Wait times for acute illness appointments may not exceed one day.
- Wait times for routine appointments may not exceed one week.
- Facilities and offices must be handicapped accessible, in accordance with federal and state regulations.

Report Tracking

The TRICARE West Region contract requires providers to submit their specialist reports (consultation reports, discharge summaries, operative reports, etc.) to the referring provider within 10 working days of the specialty encounter 98 percent of the time. 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. TriWest has developed a tracking system in order to facilitate compliance with this new requirement. It is critically important that specialists send reports to the fax number or address provided by TriWest. Due to timelines, a fax or electronic transmittal is strongly preferred.

Specialists and facilities will receive a regular report listing all the TRICARE beneficiaries who have been referred for care and for whom a consultation report, operative report, or discharge summary, as applicable, has not been returned to the referring provider. Specialist offices are expected to respond to these lists and to indicate if the service was not provided, the report was delayed, the report has already been sent, or a copy of the report is being sent. The specialist's or facility's office staff may then compare the list

with his/her records. If a report has not been sent, the specialist is expected to forward a report to the referring provider immediately.

Specialist's response(s) may be transmitted via fax, mail, or TriWest's provider portal at www.triwest.com. For additional details, call 1-888-TRIWEST (1-888-874-9378).

Report Tracking Procedures for Referrals

Approved referrals will be entered into TriWest's medical management system. Approval notification will be sent to the beneficiary and the specialist. The beneficiary approval letter contains:

- Information on the service(s) approved
- A referral number
- The name and contact information of the specialist
- Instructions to call TriWest's interactive voice response (IVR) system to "activate" the referral

The fax to the specialist contains:

- Information on the service(s) approved
- A referral number
- Instructions to call TriWest to verify eligibility
- Instructions for submitting consultation report, discharge summary, or operative report, and the fax number or specific address to which to send report

Once the beneficiary makes the appointment with the provider listed on the approved referral, the beneficiary must call the toll-free number provided to enter the day and time of the new appointment or any subsequent appointment changes. The medical management system will create lists of members who have been referred. Lists will be sent to the referring providers for their review (via fax or through e-mail/Web portal). Referring providers are instructed to inform TriWest of any reports not received (by fax or Web portal).

Report Tracking Procedures for Specialists

The medical management system will create lists of referrals to specialists that have reports due or over due. Tracking lists will be sent to providers by fax or e-mail/Web portal. Specialists will inform TriWest of the following:

- Reports already sent (when, how, where)
- Patient no-shows
- Delays (with reason)

If the following conditions exist, TriWest staff will phone specialists:

- Reports have not been received by the 9th day after the encounter and
- Specialists have not indicated that the reports were sent or were delayed.

Report Tracking Procedures for Facilities

The medical management system will generate lists of missing operative reports or discharge summaries, sorted by facility. Each facility will receive a copy of these lists with a request for review and response. TriWest staff will call any facilities who do not respond to follow up on the operative reports and/or discharge summaries.

Report Tracking Procedures for Urgent/Emergency Care

A fax will be generated to the facility once the authorization is entered into TriWest's system. The medical management system will generate a list of all authorized urgent or emergency care. TriWest staff will contact the referring provider to determine whether or not a treatment summary was received. If the summary was not received, TriWest's staff will contact the facility to obtain the necessary information and forward it to the PCM.

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 allowed 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 TriWest at 1-888-TRIWEST (1-888-874-9378). The beneficiary's responsibility is reflected on the explanation of benefits (EOB), the provider's remittance advice, or the form 835 (electronic transaction).

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 billable amount to the beneficiary. Balance billing applies only to services covered by TRICARE. A general statement of financial liability does not meet TRICARE criteria.

When providers do not accept assignment on a claim, non-network, nonparticipating providers can collect applicable deductibles and/or cost-shares and any outstanding amounts up to 15 percent above the allowable charge (shown on the remittance advice) from a TRICARE Standard beneficiary. If the billed charge is less than the TRICARE-allowed amount, the billed charge becomes the billable amount to the beneficiary.

Balance billing applies only to services covered by TRICARE. TRICARE's balance-billing limit also applies when other health insurance (OHI) is involved. Providers are limited to collecting the amount described above, regardless of the beneficiary's OHI financial responsibility. When OHI is involved, the provider of care may receive no more than the TRICARE allowable charge, or if a non-network, nonparticipating provider, 115 percent of the allowable charge through payment by the other health insurer and TRICARE. Providers may not collect any amount from a beneficiary after payment of the claim unless TRICARE and the OHI combined have failed to pay the allowable charge. In the case of a network provider, the contractually negotiated amount is the allowable charge.

Non-compliance with these balance-billing requirements by any TRICARE provider may affect that provider's TRICARE and/or Medicare status. Additional information on this topic may be obtained by visiting www.tricare.osd.mil.

Waiver of Limitation

A waiver of limitation allows a non-network, nonparticipating provider (i.e., one who does not accept assignment) to collect billed charges from the TRICARE beneficiary when that beneficiary has agreed, in advance and in writing, to waive his/her balance-billing protection. The Waiver of Limitation Form is available online at www.triwest.com or in the Tear Out Forms section of this handbook. This waiver is not valid when signed under duress or if signed after the rendered service. This waiver may also not be used when treating active duty service members. A waiver of limitation must include:

- The date
- The beneficiary's name
- The specific service or procedure
- The amount for which the beneficiary will be responsible
- A statement indicating the beneficiary agrees to waive his/her balance-billing protection
- The beneficiary's signature
- The date signed

A general statement of financial liability **does not** satisfy this requirement. Non-network, nonparticipating providers may call their TRICARE field representative at 1-888-TRIWEST (1-888-874-9378) to obtain a copy of the waiver of limitation form.

Waiver of Non-Covered Services

A network provider can utilize the waiver of non-covered services when the beneficiary is properly informed, in advance, that TRICARE does not cover a particular service and he/she agrees in writing to be financially responsible. Non-covered services are considered TRICARE exclusions and limitations (see section entitled "Medical Coverage"). The Waiver of Non-Covered Services Form is available online at www.triwest.com or in the Tear Out Forms section of this handbook. This waiver may not be used for TRICARE services that are not payable for other than benefit reasons (e.g., ClaimCheck® edits, administrative expenses, and the difference between the allowed amount and paid amount). This waiver also may not be used when treating

active duty service members. Waivers of non-covered services must be submitted in writing and include the following:

- Indication that the rendering provider is a network provider
- Indication that the beneficiary is enrolled in TRICARE Prime or using TRICARE Extra coverage
- 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
- The beneficiary's signature
- The date signed

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

Release of Patient Information

If an inquiry is made by a beneficiary, including an eligible dependent child, regardless of age, the reply should be addressed to the beneficiary, not the beneficiary's parent or guardian. The only exceptions are:

- When a parent writes on behalf of a minor child (under 18 years old)
- When a guardian writes on behalf of a physically or mentally incompetent beneficiary

In responding to a parent or guardian in the above circumstances, the Privacy Act of 1974 precludes disclosure of sensitive information which, if released, could have an adverse effect on the beneficiary.

Providers must not furnish information to the parents or guardians of minors or incompetents when services are related to the following diagnostic codes:

AIDS:
ICDM-9-CM 079.53; 042
Alcoholism:
ICDM-9-CM 291.9; 303-303.9; 305
Abortion:
ICDM-9-CM 634-639.9; 779.6
Drug Abuse:
ICDM-9-CM 292-292.2; 304-304.9; 305.2-305.9
Venereal Disease:
ICDM-9-CM 090-099.9; 294.1

TRICARE beneficiaries must maintain a "signature on file" in the physician's office to protect the patient's privacy, for the release of important information, and to prevent fraud. A new signature is required every year for professional claims submitted on a CMS-1500 and every admission for claims submitted on a . UB-92. Claims submitted for diagnostic tests, test interpretations, or other similar services do not require the beneficiary's signature. Providers submitting these claims must indicate "patient not present" on the claim form.

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

The first claims submission on behalf of the beneficiary should include the legal documentation establishing the guardian's signature authority. Subsequent claims may be stamped with "Signature on File" in the beneficiary signature box of the CMS-1500 or UB-92 claim form.

- If the beneficiary is without legal representation, the provider must submit a written report with the claims describing the patient's illness or degree of mental competence, and should annotate in Box 12, "Patient's or Authorized Representative's Signature—Unable to Sign."
- If the beneficiary's illness is temporary, the signature waiver must specify the dates the illness began and ended.
- When the beneficiary is mentally competent but physically incapable of a signature, the representative may be issued a general or limited power of attorney by signing an "X" in the presence of a notary public.

Release of Medical Records

All specialty providers are required to request that the TRICARE Prime beneficiary sign a release of medical information at each office visit (unless a signature is on file), to include ancillary services associated with each visit whereby the PCM and/or the MTF commanders are designated as the recipients of the medical records. A new signature is required every year for professional claims submitted on a CMS-1500 and every admission for claims submitted on a UB-92. Specialty providers are required to submit the medical records to the PCM and/or referring provider within 10 working days of all routine referrals. For an urgent care visit, the records should be given to the beneficiary at the time of the visit. Providers are required to submit beneficiary records for review upon request.

Under the TRICARE Prime Remote program (described in the section entitled "TRICARE Program Options"), active duty service members will be instructed to sign annual medical release forms with their PCM or TRICARE-certified providers to allow information to be forwarded to civilian and military providers. If an active duty service member is reassigned to a new location, the PCM shall provide complete copies of medical records and specialty and ancillary care documentation to the service member within 30 calendar days of the request.

Hold Harmless Policy

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, beneficiaries may sign a waiver agreeing to pay for non-covered services. However, if the provider does not obtain a legal signed waiver, and the care is not authorized by TriWest, the provider is expected to accept full financial liability for the cost of the care. In addition, the waiver signed by a beneficiary after the care is rendered is not valid under TRICARE regulations. 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) of service and billed amounts are documented.

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

Providers should maintain copies of the waiver in their office and fully inform beneficiaries in advance when specific services or procedures are not covered. See section entitled "Medical Coverage" for a summary of TRICARE covered and non-covered services and benefits.

Clinical Quality Management

TriWest has established the Clinical Quality Management Program (CQMP) to monitor medical or surgical and behavioral health care services delivered to TRICARE beneficiaries. The CQMP is designed to monitor providers' clinical performances and practice patterns.

TriWest profiles network and non-network providers when evaluating the delivery of health care services. This process includes identifying potential quality-of-care issues, identifying opportunities for improvement, and implementing corrective action plans. TriWest profiles physicians and other providers to assess quality and cost efficiency of the health care services provided.

Provider Participation

Providers are required to participate in quality management 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 TriWest and other designated DoD Utilization Management contractors and to the National Quality Monitoring Contractor (NQMC), and must authorize the release of information to MTF commanders regarding quality assurance activities.

Potential Quality Issue Review

The TriWest 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 indicators in accordance with the following:

- Medical or surgical visits
- Inpatient stays
- Skilled nursing
- Mental health facility
- Office visits

TriWest will categorize potential quality of care issues using the following categories:

(1) Surgical Events
(2) Product or Device Events
(3) Patient Protection Events
(4) Care Management Events
(5) Environmental Events
(6) Criminal Events

Providers may be contacted regarding these events.

"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 admission to the hospital. The signed document must be kept in the beneficiary's file. A new document is needed for each admission. If WPS or TriWest requests a copy of the beneficiary's medical record, a copy of this document, signed by the beneficiary, must be included in the file. The form may be obtained at www.triwest.com on the provider portal. Network providers may also contact their local network representative, see the chart in the section entitled "Welcome to TRICARE and the West Region." Non-network providers may contact their TRICARE field representative at 1-888-TRIWEST (1-888-874-9378) for a copy of the document.

It is important that beneficiaries are given the correct document that lists contact information for TriWest, the West Region contractor. Medicare's similar document or another TRICARE contractor's document cannot be substituted for TRICARE West Region beneficiaries.

Beneficiary Rights and Responsibilities

TRICARE beneficiaries need to understand their rights and their responsibilities. Both are listed below for your reference and copies for your office may be obtained by contacting Provider Services at 1-888-TRIWEST (1-888-874-9378).

TRICARE Beneficiaries Have the *Right* to...

- Receive all covered, medically necessary care
- Receive complete and accurate information about the program through written materials, presentations, and from TRICARE representatives
- Have their medical information kept confidential
- Receive considerate, courteous care that is respectful of their privacy and dignity
- Receive and review information about diagnosis and treatment, and the progress of their condition
- Be involved in decisions about their treatment
- File a grievance in writing if they have a complaint that cannot be resolved informally
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage

TRICARE Beneficiaries Have the *Responsibility* to...

- Contact their PCM (if enrolled in TRICARE Prime) to receive treatment or a referral in nonemergency situations, including urgent situations
- Follow the prescribed medical instructions given by their PCM or other care provider
- Provide complete information about their health care status to their health care providers
- Participate in decisions about their treatment
- Read and understand all TRICARE materials
- Inform the DSO and TriWest of status change(s)
- Provide information concerning OHI
- Follow prescribed procedures for TRICARE Prime enrollment portability when moving to another TRICARE region
- Inform contractor(s) of TRICARE Prime split-enrollment status

Military Treatment Facilities

A military treatment facility (MTF) is a military hospital or clinic on or near a military base. The contracted provider network augments the resources available in the MTF.

Network providers may work closely with MTF providers near them. To locate MTFs in the West Region, visit the MTF Locator at www.tricare.osd.mil/mtf.

Priorities for Care

Beneficiaries may receive care in the MTF in the following order of priority:

- Active duty service members (ADSMs)
- Active duty family members (ADFMs) who are enrolled in TRICARE Prime (survivors of military sponsors who died on active duty who are enrolled in TRICARE Prime are included in this priority group during the time period they are eligible). ADFMs who are enrolled in TRICARE Plus fall into this category for primary care appointments only.
- Retirees, their family members, and survivors who are enrolled in TRICARE Prime
- ADFMs who are NOT enrolled in TRICARE Prime (survivors of military sponsors who died on active duty who are not enrolled in TRICARE Prime are in this priority group). These beneficiaries may enroll in the TRICARE Plus program to receive primary care within an MTF*.
- Retirees, their family members and survivors who are not enrolled in TRICARE Prime. These beneficiaries may enroll in the TRICARE Plus program*.
- All other eligible beneficiaries

*See the section entitled “TRICARE Program Options” for information about TRICARE Plus.

There are certain special provisions in the MTF access policy. Visit the TRICARE Web site at www.tricare.osd.mil for more details.

MTF First Right of Refusal

MTFs are given the first “right of refusal” for TRICARE Prime beneficiaries for inpatient admissions, specialty appointments, procedures requiring prior authorizations, and procedures requiring written prior authorization. This means that TRICARE Prime beneficiaries must first try to obtain these services at an MTF. If the service is not available at the MTF within the appropriate access standards, then the beneficiary is referred to a TRICARE network provider. TriWest must be contacted at 1-888-TRIWEST (1-888-874-9378) and may request additional information, as required.

Nonavailability Statements for Inpatient Care

A nonavailability statement (NAS) is a certification from an MTF stating that it cannot provide a specific required service at a particular time to a non-enrolled beneficiary. Effective for admissions on or after December 28, 2003, the NAS requirement was eliminated for all inpatient admissions except for mental health admissions.

An NAS may be required for services other than mental health admissions (except for maternity care) when:

- Significant costs would be avoided if the services are performed at the MTF.
- Specific procedures must be performed at the MTF to ensure proficiency levels of the providers at the MTF.
- The lack of NAS data would significantly interfere with TRICARE contract administration.

The general elimination of the NAS requirement should not be confused with the continuing requirement of an authorization for those services requiring prior authorization. Network providers should advise TRICARE beneficiaries to check TriWest to find out if a prior authorization is required before obtaining nonemergency inpatient services.

NAS for Maternity Care

An NAS is NOT required for any maternity episode when the first prenatal visit occurs on or after December 28, 2003.

If the first prenatal visit occurred prior to December 28, 2003 (October 5, 1999 through December 27, 2003), for a beneficiary who lives in an MTF catchment area zip code who is not enrolled in TRICARE Prime, an NAS is required for nonemergency health care services related to outpatient prenatal, outpatient or inpatient delivery, and outpatient postpartum care subsequent to the visit which confirms the pregnancy.

NAS for Newborns

An NAS is NOT required for newborns with admission or birth date of December 28, 2003, or after.

In the event that a non-enrolled newborn infant born or admitted before December 28, 2003, remains in the hospital after a mother's discharge, the mother's NAS will be valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond these 15 days, a valid NAS is required for nonemergency inpatient care in the infant's name.

Additional information about the elimination of the NAS requirement is available online at www.tricare.osd.mil/tricaremanuals/.

DoD Centers of Excellence Program

The DoD Centers of Excellence program provides an enhanced model of clinical quality oversight. Any MTF performing the covered diagnosis-related groups (DRGs) may apply to participate in the program. MTFs have the option of applying in conjunction with one or more medical facilities (restricted to MTFs and federal-civilian programs) with which they have an established relationship. For more information about becoming a DoD Center of Excellence, visit the DoD Centers of Excellence Web site at www.tricare.osd.mil/coe.

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Understanding how eligibility for TRICARE is determined and your role in verifying a patient's eligibility

TRICARE Eligibility

TRICARE is available to eligible beneficiaries from any of the seven uniformed services—Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration. All eligible beneficiaries must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS). Providers should ensure patients have a valid uniformed services (military) identification (ID) card or authorization letter of eligibility. Be sure to check the expiration date and make a copy of both sides of the ID card for your files. See samples of uniformed services (military) ID cards in the section entitled, "Provider Tools."

Beneficiaries can verify their enrollment in DEERS by contacting TriWest at 1-888-TRIWEST (1-888-874-9378). As a provider, you may not verify DEERS enrollment directly because of the Privacy Act (5 U.S.C. 552a). Children under the age of 10 will probably not have an ID card. In these cases, providers should check the parent's ID card.

Important Notes about Eligibility

Family members of active duty service members lose their eligibility at midnight on the day the active duty sponsor is discharged from service, unless they have extended benefits through the Transitional Assistance Management Program.

Active duty service members *cannot* use TRICARE Standard or TRICARE Extra. They must enroll in TRICARE Prime. The service member's branch of service provides for the care of active duty service members and is responsible for paying for any civilian emergency care required by active duty members. Active-duty member claims should be mailed to TriWest for processing.

Special Eligibility Rules under Diagnosis-Related Groups

Under the TRICARE Standard diagnosis-related group (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 loses eligibility because of gaining Medicare eligibility, TRICARE becomes the secondary payer. For a patient who becomes eligible for Medicare because of age, and who is not an active duty family member, 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 was rendered before eligibility ceased.

Dual-Eligibility

Some TRICARE beneficiaries are also eligible to receive other federal benefits, such as Medicare or Veterans Affairs (VA) health care benefits. The following section discusses these dual-eligible situations. If a beneficiary is not entitled to Medicare Part A, they will need a Notice of Disallowance from the Social Security Administration to remain eligible for TRICARE.

TRICARE and Medicare

TRICARE beneficiaries under age 65 who are also entitled to Medicare Part A due to a disability or end-stage renal disease (ESRD) are considered dual-eligible. For these individuals, TRICARE coverage may continue as a secondary payer to Medicare. By law, dual-eligible beneficiaries under the age of 65 must be enrolled in Medicare Part B to retain TRICARE benefits. (The requirement to enroll in Medicare Part B does not apply to dual-eligible ADFMs regardless of age.) All other dual-eligible beneficiaries must enroll in Medicare Part B or they will not be eligible for coverage under TRICARE.

These dual-eligible beneficiaries may maintain their regular TRICARE eligibility (TRICARE Prime, TRICARE Extra, or TRICARE Standard). By law, TRICARE will pay secondary to Medicare for these beneficiaries, similar to TRICARE For Life (TFL). Dual-eligible beneficiaries are not required to pay TRICARE Prime enrollment fees. Since 1991, beneficiaries who are under age 65 and eligible for TRICARE and have Medicare Part A and Part B have been able to use TRICARE as a secondary payer to Medicare.

When TRICARE beneficiaries become entitled to Medicare Part A upon attaining the age of 65 and purchase Medicare Part B, they become eligible for TFL and TRICARE will pay secondary to Medicare. Information about TFL is available in the section entitled, "TRICARE Program Options."

TRICARE and Veterans Affairs

In some cases, beneficiaries are eligible for benefits under both the TRICARE and VA programs. These beneficiaries may choose to use their TRICARE benefit at a VA medical facility as long as the service is covered under TRICARE and is not for a service-connected condition. Veterans who choose to use TRICARE must comply with the TRICARE program rules. Care received in a VA facility for service-connected conditions must be received under veterans' benefits.

If a TRICARE/VA dual-eligible beneficiary is seeking care in a facility other than a VA facility (MTF, civilian hospital, etc.), he/she may choose to use TRICARE benefits regardless of whether it is for a service-connected condition. However, once that choice is made, the TRICARE benefit must be used to complete the entire "episode of care." An episode of care generally includes all covered services provided for a particular medical incident.

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A description of TRICARE's family of health care programs and options available to TRICARE beneficiaries

TRICARE Program Options

TRICARE's family of programs offers comprehensive medical and dental benefits to every TRICARE beneficiary category. It's important to understand the choices available and how you as a provider can assist beneficiaries in making the right choice.

TRICARE Prime

TRICARE Prime is a managed care option. TRICARE Prime offers fewer out-of-pocket costs than any other TRICARE option. TRICARE Prime enrollees receive most of their care from a military treatment facility (MTF), augmented by the TriWest Healthcare Alliance provider network. TRICARE Prime enrollees are assigned a primary care manager (PCM) who provides and coordinates for care, maintains patient health records, and refers patients to specialists, if necessary. Specialty care must be arranged and approved by TriWest to be covered under TRICARE Prime. Primary care is usually provided in an MTF, but many network providers also provide primary care to TRICARE Prime enrollees.

Active duty service members (ADSMs) are not responsible for any copayments. ADFMs enrolled in TRICARE Prime do not have copayments except for pharmacy copayments, when using the TRICARE Prime point-of-service (POS) option, or when enrolled in Program for Persons with Disabilities (PFPWD). Retirees and their families enrolled in TRICARE Prime are responsible for copayments when seeking care from a network provider. TRICARE Prime beneficiaries are not responsible for annual deductibles.

Eligibility for TRICARE Prime

TRICARE Prime is available to ADSMs, family members, and survivors of active duty personnel; retirees, their family members, and survivors under age 65; and members of the Reserve Component (RC) and their families (if the RC member is activated for more than 30 consecutive days). All eligible beneficiaries must be enrolled in Defense Enrollment Eligibility Reporting System (DEERS) and reside in a service area where TRICARE Prime is offered.

TRICARE Prime beneficiaries will present their TRICARE Prime enrollment card and uniformed services (military) identification (ID) card at the time of service. See an example of the TRICARE Prime enrollment card in the section entitled "Provider Tools."

Eligibility may be verified by calling 1-888-TRIWEST (1-888-874-9378). Eligibility is also verified as part of the prior authorization process.

Primary Care Manager

TRICARE Prime enrollees select or are assigned to a PCM. A PCM is an MTF provider or a TRICARE network provider within a TRICARE Prime service area who provides primary care services to TRICARE Prime beneficiaries.

According to TRICARE, a PCM who is practicing within the governing State's rules and regulations may be a provider of primary care services when rendering services within a Prime Service Area location. This includes the following PCM types:

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

A TRICARE Prime beneficiary relies on his/her PCM for referrals to specialty care providers and services either at an MTF or within the local network. For these services to be covered by TRICARE, the network PCM must submit a referral request (HIPAA-compliant 278

electronic transaction) to TriWest via fax to the fax number assigned to your State. (See www.triwest.com for a listing.)

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/her office
- The first eight outpatient behavioral health services provided by a network provider in a fiscal year (October 1–September 30)
- Emergency care

TriWest will assist with finding specialty care after a referral is requested. TRICARE Prime beneficiaries may be reimbursed for reasonable travel expenses if TriWest authorizes a referral to a specialist who is more than 100 miles away from the PCM's office. TRICARE Prime enrollees are required to obtain all care either from their PCM or with referrals from network providers. Refer to the section entitled, "Health Care Management and Administration" for more information about referrals and authorizations.

Point-of-Service Option

TRICARE Prime beneficiaries who utilize the POS option may self-refer to any TRICARE-certified (network or non-network) provider for medical or surgical services without a referral from his/her PCM. For behavioral health services, the POS option applies when the TRICARE Prime beneficiary receives nonemergency services from a non-network provider. Although a referral is not required when using the POS option, certain prior authorization requirements still apply. The beneficiary will pay a deductible ($300 individual and $600 family) and 50 percent of the TRICARE allowable charge. There is no catastrophic cap protection when using the POS option. Special considerations apply if the beneficiary has other health insurance.

POS is not an "accident." In other words, if a TRICARE Prime beneficiary follows the rules of the program and has a referral from the PCM, the POS option does not apply. The POS option is exercised only when the beneficiary chooses to proceed with care without a required referral or when a provider has failed to obtain an authorization for specialty care prior to rendering it under nonemergency circumstances. It is important for providers to note the end date of referrals and to advise beneficiaries when additional referrals are required.

Tips to Avoid POS in Error

The PCM should perform urgent (nonemergency) care. If the care is being performed because the PCM's office is closed or because the patient is out of area, the patient should call the 1-888-TRIWEST (1-888-874-9378) line as soon as practical to explain that the care has been rendered.

TriWest has a "no-referral" listing of labs, x-rays, and minor procedures that may be completed without referral by network providers. This testing is done as part of an episode of care approved by the PCM and does not carry a POS penalty. The listing is available at www.triwest.com. These services are subject to post service prepayment review.

Preventive services also are provided without referrals when performed by network providers. For a complete listing of preventive benefits, please refer to the section entitled, "Medical Coverage." TRICARE Prime beneficiaries in the West Region also are eligible to receive eight behavioral health visits (therapy) with network behavioral health providers before a referral is needed.

TRICARE Extra and TRICARE Standard

TRICARE Extra and TRICARE Standard are available for all TRICARE-eligible beneficiaries who choose not to enroll in TRICARE Prime. ADSMs are not eligible for TRICARE Extra or TRICARE Standard. Beneficiaries are responsible for fiscal year deductibles and cost-shares. Beneficiaries may see any TRICARE-certified provider they choose, and TRICARE will share the cost with the beneficiaries after deductibles are met.

TRICARE Extra is a preferred provider option in which beneficiaries choose a doctor, hospital, or other medical provider within the TriWest provider network.

TRICARE Standard is a fee-for-service option. Beneficiaries may seek care from any TRICARE-certified provider. The following chart shows the main differences between TRICARE Extra and TRICARE Standard out-of-pocket cost-share deductibles.

	TRICARE Extra	TRICARE Standard
Physician/ Provider	In network	Not in network, but still a certified provider
Cost-share after deductibles	15% for active duty families 20% for retirees and their families	20% for active duty families 25% for retirees and their families

Provider Responsibilities

Network providers are responsible for filing all claims with TRICARE for services rendered. Information about how to file health care claims is available in the section entitled, "Claims Processing and Billing Information." Additionally, some care provided may require prior authorization. All providers should check with TriWest at 1-888-TRIWEST (1-888-874-9378) to find out if a procedure requires prior authorization. Please see the section entitled, "Important Provider Information" for more specific information about balance billing, office and appointment access standards, and other provider responsibilities.

Catastrophic Cap Benefit

TRICARE beneficiaries have a catastrophic cap that limits their out-of-pocket liability on copayments, cost-shares, and deductibles.

- Active duty family members enrolled in TRICARE Prime or utilizing TRICARE Extra or TRICARE Standard benefits have a catastrophic cap of $1,000 per fiscal year.
- All other TRICARE Prime beneficiaries (retirees, family members of retirees, survivors, former spouses) have a catastrophic cap of $3,000 per enrollment period, which is only applicable to enrollment fees, outpatient and inpatient cost-shares, and copayments. POS cost-shares and the deductible shall not be applied to the TRICARE Prime beneficiary's $3,000 catastrophic cap limit, but will be applied to his/her fiscal year catastrophic cap of $3,000.
- The TRICARE Prime beneficiary's out-of-pocket cost while utilizing POS is accrued against the catastrophic cap. However, there is no cap on POS out-of-pocket expenses. The beneficiary cost-share will remain at 50 percent of the TRICARE allowable charge even after the catastrophic cap has been reached.
- TRICARE Standard beneficiary families (retirees, dependents of retirees, survivors, former spouses) have a catastrophic cap of $3,000 per fiscal year.

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

TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) provide health care coverage through civilian network or TRICARE-certified providers for ADSMs and their families who are on remote assignment, typically 50 miles or a one hour drive time from an MTF. TPR and TPRADFM are offered in the 50 United States only, and both require enrollment with TriWest for participation.

Similar to TRICARE Prime, TPR and TPRADFM beneficiaries choose a PCM to provide primary care services and coordinate specialty care. In some cases, however, TPR and TPRADFM may have to choose a non-network TRICARE-certified provider as their PCM if there are no network providers in their area. These beneficiaries can also receive services from military providers, if they are willing to travel to the MTF.

ADSMs can receive primary care services without a referral, prior authorization, or fitness-for-duty review. Specialty and inpatient care will require a referral and prior authorization. Those who do not have a PCM must coordinate requests for specialty care through TriWest and the Service Point of Contact (SPOC). The SPOC will determine if the specialty care should be referred to a military physician for a fitness-for-duty determination or to a TRICARE-certified provider. Contact TriWest at 1-888-TRIWEST (1-888-874-9378) for more information or assistance.

Using the POS Option

The POS option does not apply for TPR ADSMs. If they receive care without a referral or prior authorization, the claim will be processed and paid after approval by the SPOC. They do not have copayments, cost-shares, or deductibles. However, TPRADFM beneficiaries are subject to the same POS provisions as TRICARE Prime. They must coordinate care with their PCM, or they will be required to pay the higher 50 percent cost-share and deductible ($300 individual and $600 family).

TRICARE For Life

TRICARE For Life (TFL) is a program option available for uniformed services retirees, their spouses, and survivors age 65 and over who are entitled to Medicare Part A and enrolled in Medicare Part B. TFL is available as secondary coverage to Medicare in addition to offering access to TRICARE services that may not be covered under Medicare. TRICARE pays secondary to Medicare beginning on the first day of the month that the beneficiary turns 65. In most cases, Medicare will pay first, and the remaining out-of-pocket expenses will be paid by TRICARE. Wisconsin Physicians Service (WPS) administers TFL.

Covered Services

- For TRICARE and Medicare-covered services, Medicare pays first in most cases, and TRICARE pays its share of the remaining expenses second.
- For services covered by TRICARE, but not by Medicare, TRICARE pays first and the beneficiary is responsible for any TRICARE deductibles and cost-shares.
- For services covered by Medicare, but not by TRICARE, Medicare is the only payer and the beneficiary is responsible for Medicare cost-shares.
- For services not covered by Medicare or TRICARE, the beneficiary is responsible for all costs.

For services received from a civilian provider, the provider will first file claims with Medicare. Medicare will pay its portion and automatically forward the claim to TRICARE for processing. TRICARE will send its payment for the remaining beneficiary liability directly to the provider, and beneficiaries will receive a Medicare summary notice and a TFL explanation of benefits (EOB) that indicates the amount paid to the provider. See the description about filing dual-eligible claims in the section entitled, “Claims Processing and Billing Information.”

TRICARE Plus

TRICARE Plus is a primary care enrollment program that is offered at selected MTFs. All beneficiaries eligible for care in MTFs (except those enrolled in TRICARE Prime, a civilian HMO, or Medicare HMO) can seek enrollment for primary care at MTFs where the enrollment capacity exists. Non-enrollment in TRICARE Plus does not affect TFL benefits or other existing programs. Beneficiaries should contact their local MTF to find out if they may participate in TRICARE Plus.

TRICARE Pharmacy Program

TRICARE provides a world-class pharmacy benefit. TRICARE beneficiaries are eligible for the TRICARE Pharmacy Program, including Medicare-eligible beneficiaries age 65 and over, and can fill prescription medications at MTF pharmacies, through the TRICARE Mail Order Pharmacy (TMOP), or at retail network and non-network pharmacies. All beneficiaries must have their address and other information updated in DEERS. To have a prescription filled, beneficiaries will need a written prescription and a valid uniformed services ID card. Medicare-eligible

beneficiaries who turned age 65 on April 1, 2001, or later, must be enrolled in Medicare Part B.

Generic Drug Use Policy

It is a Department of Defense (DoD) policy to substitute generic medications for brand-name medications when available. Brand-name drugs that have a generic equivalent may be dispensed only if the prescribing physician is able to justify medical necessity for use of the brand-name drug in place of the generic equivalent. If a generic equivalent drug does not exist, the brand-name drug will be dispensed at the brand-name copayment.

Drug/Medication Coverage

The DoD Pharmacy and Therapeutics Committee has established quantity limits on certain medications, which means that DoD will pay only for up to a specified quantity per 30-, 60-, or 90-day supply. Quantity limits are applied to address the problem of overuse of medications that can be unsafe for the patient and costly to the government. Exceptions to established quantity limits can be made if the prescribing physician is able to justify medical necessity.

Certain medications, such as Enbrel, Lamisil, Sporanox, and Viagra, require prior authorization before they can be obtained from a retail pharmacy under the TRICARE program. A prior authorization request is necessary to ensure that clinically appropriate treatment regimens are followed. Drugs that require prior authorization are usually medications that are not the first step in a treatment regimen.

There are specific drugs for which DoD has awarded contracts with pharmaceutical manufacturers that apply to the MTF pharmacies and the mail order program. As a result, some drugs that can be obtained from a retail pharmacy cannot be obtained from MTF pharmacies or the mail order program. Non-contracted medications, such as Lipitor, Prevacid, and Protonix, can only be dispensed from the mail order program when medical necessity is substantiated. However, they can be obtained at a retail pharmacy without medical justification and will be covered by TRICARE.

TRICARE covers all Food and Drug Administration (FDA) approved prescription drugs approved for outpatient use with some exclusions established by law. Additionally, some drugs require prior authorization. For a general list of prescription drugs that are covered under TRICARE's outpatient pharmacy benefit and for drugs requiring prior authorization or quantity limits at TRICARE retail network pharmacies, visit www.express-scripts.com/TRICARE or call 1-866-DoD-TRRx (1-866-363-8779). For a listing of FDA-approved drugs, visit the FDA Web site at www.fda.gov/cder/ob/default.htm.

TRICARE Pharmacy Options

MTF Pharmacies

Prescriptions may be filled (up to a 90-day supply for most medications) at an MTF pharmacy free of charge. Each facility is required to make available the medications listed in the DoD basic core formulary. The MTF, through its local pharmacy and therapeutics committee, may add additional medications to its local formulary based on the scope of care at that MTF. Beneficiaries should contact their local MTF for specific details about filling and refilling prescriptions at its pharmacy. MTF pharmacies will accept written prescriptions from any TRICARE-certified provider.

TRICARE Mail Order Pharmacy (TMOP)

TMOP is available for prescriptions that beneficiaries take on a regular basis. Beneficiaries may receive up to a 90-day supply for most medications. TMOP is administered by Express Scripts, Inc. Through this program, beneficiaries mail (or providers may fax) their health care provider's written prescription along with the appropriate copay to TMOP, and the medications will be sent directly to the beneficiary. Prescriptions may be refilled by mail, phone, or online.

For more information about how to use TMOP, beneficiaries may visit the TRICARE Web site at www.tricare.osd.mil/pharmacy/tmop.cfm or contact TMOP member services at 1-866-DOD-TMOP (1-866-363-8667) within the U.S., or 1-866-ASK-4PEC (1-866-275-4732) outside the U.S. They may also visit the Express Scripts Web site at www.express-scripts.com/TRICARE.

TRICARE Retail Pharmacy Network

Beneficiaries may fill prescriptions at pharmacies in the TRICARE network. The TRICARE Retail Pharmacy Network is administered by Express Scripts, Inc. For more information, please contact Express Scripts, Inc. at www.express-scripts.com/TRICARE or call 1-866-DoD-TRRx (1-866-363-8779).

Non-network Pharmacies

Filling prescriptions in non-network pharmacies is the most expensive option and is not recommended. Beneficiaries may have to pay for the total amount first and file a claim to receive a partial reimbursement.

Pharmacy Copayments

Place of Service	Generic	Brand Name
MTF Pharmacy	$0	$0
TMOP (up to a 90-day supply)	$3	$9
Retail Network Pharmacy (up to a 30-day supply)	$3	$9
Non-network Pharmacy	1. $9 or 20% of total cost (whichever is greater) 2. Existing deductibles and point-of-service (POS) penalty apply: E-4 and below, TRICARE Standard, $50 per person/$100 per family; E-5 and above, TRICARE Standard, $150 per person/$300 per family; TRICARE Prime, $300 per person/$600 per family, POS penalty–50% of the allowed amount.	

Pharmacy Data Transaction Service

The Pharmacy Data Transaction Service (PDTS) creates a global centralized data repository that records information about prescriptions filled for DoD beneficiaries at MTFs, the TRICARE retail pharmacy network, and the TMOP program. PDTS improves the quality of prescription services and enhances patient safety by reducing the likelihood of adverse drug-drug interactions, therapeutic overlaps, and duplicate treatments across the highly transient population of active duty and retired beneficiaries. PDTS conducts an online prospective drug utilization review (a clinical screening) against a beneficiary's complete medication history for each new or refilled prescription in real-time before it is dispensed to the patient. Regardless of where a beneficiary fills a prescription within the MHS, information about the prescription is stored in a robust central data repository and is available to authorized PDTS providers as a seamless enhancement to the current workflow processes. The PDTS provides the means for application of benefit design rules for consistency across all points of service available to DoD beneficiaries.

TRICARE Dental Programs

TRICARE currently offers two dental programs to meet the needs of its beneficiary population: the TRICARE Dental Program and the TRICARE Retiree Dental Program.

TRICARE Dental Program

The TRICARE Dental Program (TDP) is a voluntary dental insurance program, administered and underwritten by United Concordia Companies, Inc. (UCCI), that is available to eligible active duty family members (ADFMs), Selected Reserve and Individual Ready Reserve (IRR) members, and their eligible family members. Active duty personnel (and Reservists called to active duty for a period of more than 30 days) are not eligible for the TDP. They receive dental care from military dental treatment facilities. Former spouses, parents, parents-in-law, disabled veterans, foreign military personnel, and uniformed services retirees and their families are not eligible for the TRICARE Dental Program. Other details of TDP benefits, requirements, and restrictions can be found at the UCCI Web site at www.ucci.com/was/ucciweb/home.jsp.

TRICARE Retiree Dental Program

The TRICARE Retiree Dental Program (TRDP) is a voluntary dental insurance program

administered and underwritten by the Federal Services division of Delta Dental Plan (DDP) of California. The TRDP offers comprehensive, cost-effective dental coverage for uniformed services retirees and their eligible family members, as well as certain surviving family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors. Other details of TRDP benefits, requirements, and restrictions can be found at the DDP Web site at www.trdp.org.

TRICARE for the Reserve Component

Members of the Reserve Component (RC) who are called to active duty for more than 30 consecutive days are eligible for TRICARE, the same as any ADSM. Families of these individuals also become eligible for TRICARE if the sponsor is called to active duty for more than 30 consecutive days. To ensure family members are eligible for TRICARE upon activation, sponsors should register their family members in the DEERS.

Programs Available to the Reserve Component

Family members of the RC become eligible for TRICARE Extra and TRICARE Standard on the first day of the military sponsor's active duty if his/her orders are for more than 30 consecutive days or if the orders are for an indefinite period. Family members must be enrolled in the DEERS to document their eligibility. There is no enrollment required for TRICARE Standard or TRICARE Extra. There is an annual fiscal year deductible and cost-shares. They also become eligible for the TRICARE Pharmacy Program and may have prescriptions filled at MTF pharmacies, through the TMOP, or at retail pharmacies. The TRICARE Pharmacy Program has its own cost-shares separate and apart from all other programs. Eligible family members may enroll in TRICARE Prime if their sponsor is called to active duty for more than 30 days. If eligibility criteria are met, eligible family members may enroll in TRICARE Prime Remote for Active Duty Family Members. There are no enrollment fees or co-payments for family members, but enrollment forms must be completed, and MTFs or TRICARE Prime network providers must be used. Many RC families may have continuing relationships with providers who are not in the TRICARE Prime network. In these cases, enrolling in TRICARE Prime may not be the best choice—instead, using TRICARE Standard can be the most flexible option, even though beneficiaries may be required to pay a share of the cost of health care. If family members are eligible for the TRICARE Reserve Family Demonstration Project (see the next section), the TRICARE Standard deductible will be waived.

Members of the Selected Reserve and Individual Ready Reserve (IRR) and/or their families may enroll in the TRICARE Dental Program (TDP). RC members who are ordered to active duty for more than 30 consecutive days are eligible for military dental care, the same as ADSMs, and members are automatically disenrolled from the TDP if previously enrolled.

When RC members retire, they do not become eligible for TRICARE or space-available care in an MTF until they reach age 60 or are receiving retired pay. At that time, they and their family members may enroll in TRICARE Prime or they may use TRICARE Extra or TRICARE Standard. Retired RC members also become eligible for TRICARE For Life (TFL) when they become eligible for Medicare at age 65 and enroll in Medicare Part B. In addition, retired RC members and their spouses and dependent children are eligible for the TRICARE Retiree Dental Program (TRDP), regardless of the sponsor's age and whether the sponsor is receiving retired pay.

TRICARE Reserve Family Demonstration Project

The TRICARE Reserve Family Demonstration Project is effective for health care services received on or after September 14, 2001, and it is nationwide. Demonstration participants are limited to families of Reserve and National Guard members called to active duty for periods of more than 30 days in support of operations that result from the terrorist attacks of September 11, 2001, under Executive Order 13223, 10 U.S.C. 12302, 10 U.S.C. 12301(d), or

32 U.S.C. 502(f). Such operations include, for example, OPERATIONS ENDURING FREEDOM, NOBLE EAGLE, and IRAQI FREEDOM.

TRICARE Reserve Family Demonstration Project components include:

- Waiver of TRICARE Standard annual deductible
- Waiver of the TRICARE allowable charge under TRICARE Standard
- Waiver of nonavailability statement (NAS) requirement for nonemergency inpatient care

Temporary Reserve Health Care Benefits for 2004

The recently enacted Emergency Supplemental Appropriations Act and the National Defense Authorization Act for Fiscal Year 2004 authorized temporary health care benefits for TRICARE eligibility for eligible RC sponsors and family members.

TRICARE Management Activity (TMA) is working closely with Reserve Affairs and the uniformed services to implement these temporary benefits for the RC and their families. Please visit the TRICARE Web site at www.tricare.osd.mil for new information about these temporary benefits as the details are made available. Additionally, information about the benefits will be highlighted in provider newsletters, bulletins, and other educational materials in the future.

Department of Defense/ National Cancer Institute Demonstration Program

The DoD joined forces with the National Cancer Institute (NCI) through an interagency agreement, known as the DoD/NCI Cancer Clinical Trials Demonstration Project, to offer TRICARE beneficiaries and the health professionals who care for them the latest in both cancer preventive care and treatment. Under this agreement, beneficiaries can participate in NCI-sponsored cancer prevention and treatment studies as part of their TRICARE health care benefits.

The clinical trials can offer people at risk for cancer and people diagnosed with cancer some of the most promising advances in cancer research. For some TRICARE beneficiaries with cancer, the DoD/NCI Clinical Trials project offers choices when few treatment options exist. However, before patients and their doctors decide whether or not to participate in a clinical trial, there are many important questions to consider.

As a physician or health professional, you are dedicated to providing the latest, most effective medical care for your patients. If you care for patients with cancer or at risk for cancer, offering them an option to enroll in clinical trials sponsored by the NCI may give them access to the most promising advances in cancer research.

For more information visit www.tricare.osd.mil/cancertrials.

Program for Persons with Disabilities

The Program for Persons with Disabilities (PFPWD) provides financial assistance to reduce the effects of a qualifying condition. It is not a stand-alone program; subject to certain restrictions, it may be used concurrently with other TRICARE programs. The PFPWD is not an enrollment program. Only family members of active duty service members are eligible for the program. PFPWD serves persons with a moderate or severe mental retardation or a serious physical disability.

Active duty family members, or persons acting on their behalf, who apply for benefits under the PFPWD must show that the medical condition qualifies them for the program and that the requested benefits are necessary and appropriate.

All program benefits must be authorized in advance. Beneficiaries should contact a beneficiary counseling and assistance coordinator (BCAC) for guidelines on the type of information required to establish the existence of a qualifying medical condition and to establish the need for the benefits requested.

The PFPWD will be replaced during 2004 by the new TRICARE Extended Care Health Option (ECHO). Information about TRICARE ECHO will be provided as the new program rolls out in the TRICARE West Region, and beneficiaries currently receiving PFPWD benefits will be contacted about the new TRICARE ECHO program. Please advise beneficiaries to visit the TRICARE Web site at www.tricare.osd.mil for additional information.

Supplemental Health Care Program

The Supplemental Health Care Program (SHCP) provides coverage for ADSMs (except those enrolled in TPR) and non-active duty individuals under certain conditions when referred to civilian providers for certain services or treatments. While the SHCP is also funded by the DoD, it is separate from TRICARE. Only the following individuals are eligible for the SHCP:

- ADSMs assigned to a military treatment facility (MTF)
- 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 primary care manager (PCM) or other provider who is not an MTF PCM
- Reserve Component (RC) members on active duty
- National Guard members (line-of-duty care only, unless beneficiary is on active federal service)
- National Oceanic and Atmospheric Administration, U.S. Public Health Service, cadets or midshipmen, and eligible foreign military personnel
- Non-active duty beneficiaries—when an inpatient in an MTF, and 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 the procedure.
- Comprehensive Clinical Evaluation Program participants
- Dependent parents or parents-in-law with MTF approval

To verify patient eligibility for the SHCP, call TriWest at 1-888-TRIWEST (1-888-874-9378).

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 Military Medical Support Office (MMSO) will be covered under the SHCP. SHCP individuals are not responsible for deductibles, cost-shares, or copayments.

Referrals and Authorization

The MTF (if one is available) 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 DD Form 2161 (this form may vary by the MTF site) will be completed and sent to TriWest prior to sending the patient for specialty care. TriWest and the MTF or the Service Point of Contact (SPOC), 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.

Provider Responsibilities

Network providers are required to adhere to all contract requirements when treating SHCP individuals, including office and appointment access standards. Refer to the section entitled, “Important Provider Information” for more information about provider responsibilities.

TriWest 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 ensure 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. Providers may receive reimbursement for medical records copying fees by sending the charges on a standard invoice or statement to:

TriWest Healthcare Alliance
Attn: TPR/SHCP Unit
P. O. Box 42178
Phoenix, AZ 85080

Claims Submission

Claims for the SHCP are processed and paid through WPS and must be sent to the address below:

Wisconsin Physicians Service (WPS)
P.O. Box 77028
Madison, WI 53707-7028

Claims may be filed electronically at www.triwest.com

Transitional Health Care Benefits

TRICARE offers options for those beneficiaries who are separating from active duty. These options are described below.

Continued Health Care Benefit Program

The Continued Health Care Benefit Program (CHCBP) is intended to provide transitional benefits for a specified period of time (18–36 months) to former service members and their families, some un-remarried former spouses, and emancipated children (living on their own) who enroll and pay quarterly premiums. The benefits available under CHCBP are similar to TRICARE Standard, and although it is not part of TRICARE Standard, it operates under most of the same rules. The quarterly premiums for the coverage are $933 for one person and $1,996 for a family. To receive coverage under CHCBP, eligible persons must enroll within 60 days after separating from active duty or from losing their eligibility for military health care.

The DoD has contracted with Humana Military Healthcare Services, Inc., to help administer the CHCBP. Beneficiaries may contact Humana Military Healthcare Services, Inc., in writing or by phone for any information regarding CHCBP at the following address or phone number:

Humana Military Healthcare Services, Inc.
Attn: CHCBP
P.O. Box 740072
Louisville, KY 40202
1-800-444-5445

Transitional Assistance Management Program

The Transitional Assistance Management Program (TAMP) allows that certain uniformed service and family members may be eligible for transitional health care benefits when the sponsor separates from active duty service. Service member categories include:

- A member who is involuntarily separated from active duty
- A Reserve Component (RC) member who is separated from active duty and who was called up or ordered in support of a contingency operation for an active duty period of more than 30 days
- A member who is separated from active duty and is involuntarily retained in support of a contingency operation
- A member who is separated from active duty following a voluntary agreement to stay on active duty for a period of less than one year in support of a contingency mission

Voluntary Separation Benefits

Service members voluntarily separated under the Special Separation Benefit (SSB) or the Voluntary Separation Incentive (VSI) are entitled to all benefits provided to involuntarily separated members. Members who choose SSB or VSI (and their families) may receive health benefits by enrolling in the CHCBP.

TriWest's Population Health Improvement Department

TriWest's Population Health Improvement Department (PHID) offers multiple programs for eligible beneficiaries. These programs include disease management, demand management, and health and wellness programs. The PHID is dedicated to providing information and support that will improve health care outcomes through education. Education is provided over the phone, via e-mail, and through regular mail. Participation is entirely through an "opt-in" process by our beneficiaries to any of the programs. As new disease issues are identified for which intervention can be undertaken, new programs may be developed.

Disease Management

TriWest currently has a program for eligible diabetic patients that includes adult, pediatric, and gestational diabetes. The program focuses on education and assistance for beneficiaries who have been diagnosed with *diabetes mellitus*, both type I and type II. A cardiac disease program also is available that focuses on beneficiaries with a new *myocardial infarction* (diagnosis code 410.0–410.90) or *unstable angina pectoris* (diagnosis codes 413.0–413.90). All TRICARE-eligible beneficiaries may participate in the cardiac disease program.

Demand Management

TriWest has an audio library available to answer many of our beneficiaries' health care questions. The number is 1-888-259-9375. A CRISIS line is available for any behavioral health issues. The number is 1-888-TRIWEST (1-888-874-9378). After dialing the main number, the interactive voice response (IVR) system will direct providers through a series of responses to the correct location. These toll-free numbers are accessible 24 hours a day. Information about health care is also available via TriWest's Web site portal at www.triwest.com.

Health and Wellness

TriWest offers health and wellness information via our TriWest Web site portal at www.triwest.com. There are also links to many DoD health improvement sites.

Referrals to PHID Programs

TriWest encourages providers to refer beneficiaries with targeted conditions to one of the PHID programs. The sooner the beneficiary can become involved in the program, the sooner he/she can begin to benefit from its educational and support-related features. Beneficiaries may also self-refer to any of TriWest's programs. Some MTFs in the West Region also have population health improvement programs. TriWest will work with the MTFs to avoid duplication for beneficiaries enrolled to MTFs.

To refer a TRICARE beneficiary to a program, contact TriWest's PHID staff at 1-888-259-9375 or fax the request to 1-888-212-1769. A form is also available on the TriWest provider portal Web site at www.triwest.com. Referral to PHID programs can be made at any time.

Notes

A summary of TRICARE-covered services including limitations and exclusions

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. Some military treatment facilities (MTFs) may offer services, procedures, or benefits that are not necessarily covered under TRICARE. Beneficiaries should contact their local MTF for more information.

The following charts and information summarize TRICARE-covered and non-covered services.

Please note that TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) offer coverage similar to TRICARE Prime. For additional information or specific questions about covered services, contact TriWest at 1-888-TRIWEST (1-888-874-9378) or review the TRICARE Policy Manual, TRICARE Reimbursement Manual, and TRICARE Operations Manual online at www.tricare.osd.mil.

Outpatient Services Outside of a Military Treatment Facility

Outpatient services received in an MTF are at no cost to the beneficiary. For the charts on the following pages, "ADFM" is the active duty family member responsibility.

Services Covered	TRICARE Prime**	TRICARE Extra*	TRICARE Standard*
Ancillary Services Certain diagnostic radiology and ultrasound (70000-76999); diagnostic nuclear medicine (78000-78999); pathology and laboratory services (80000-89399); and cardiovascular studies (93000-93350)	Per visit: **ADFM:** No copayment **Retirees and others:** No copayment	**ADFM:** 15% of contracted reimbursement **Retirees and others:** 20% of contracted reimbursement	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** 25% of the maximum allowable charge
Ambulance Services When medically necessary and when needed for a medical condition that is covered by TRICARE	Per occurrence: **ADFM:** No copayment **Retirees and others:** $20 copayment	*Same as above*	*Same as above*
Ambulatory Surgery (Same Day)[1] When surgery is conducted at a hospital-based or freestanding ambulatory surgical center that is TRICARE-certified TRICARE Prime Retirees and others—copayment is applied to the ambulatory surgical facility only.	Per occurrence: **ADFM:** No copayment **Retirees and others:** $25 copayment	**ADFM:** $25 copayment **Retirees and others:** Professional—20% of contracted reimbursement Facility—20% of contracted reimbursement	**ADFM:** $25 copayment **Retirees and others:** Professional—25% of the maximum allowable charge Facility—25% of the group rate or 25% of billed charges; whichever is less

**Cost-share is applied after deductible has been satisfied.*

***Benefits under TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) are similar to TRICARE Prime.*

1. *TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.*
2. *If provided as part of an office visit and a copayment is collected for the visit under TRICARE Prime, no additional copayment will be collected for these services.*
3. *Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.*

Outpatient Services Outside of a Military Treatment Facility (continued)

Services Covered	TRICARE Prime**	TRICARE Extra*	TRICARE Standard*
Durable Medical Equipment (DME), Prosthetic Devices and Medical Supplies (Prescribed by a Physician)[1][3] For DME, prosthetic devices, and medical supplies, care is subject to TRICARE policy after an office or home health visit when medically necessary and a covered benefit.	**ADFM:** No copayment **Retirees and others:** 20% of contracted reimbursement	**ADFM:** 15% of contracted reimbursement **Retirees and others:** 20% of contracted reimbursement	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** 25% of the maximum allowable charge
Emergency Services[1] Emergency care obtained on an outpatient basis, both network and non-network, in or out of the region.	Per visit: **ADFM:** No copayment **Retirees and others:** $30 copayment	*Same as above*	*Same as above*
Eye Examinations One routine examination per year for active duty family members. For additional coverage, see "Eye Examinations" under Clinical Preventive Services Benefits.	**ADFM:** No copayment **Retirees and others:** Not covered	**ADFM:** 15% of contracted reimbursement **Retirees and others:** Not covered	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** Not covered
Home Health Care[3] Same as the Medicare home health care benefit, providing a maximum of 28 hours per week part time, or 35 hours per week intermittent, skilled nursing care and physical, speech, and occupational therapy. All care must be provided by a participating home health care agency.	Per visit: **ADFM:** No copayment **Retirees and others:** $12 copayment	**ADFM:** 15% of contracted reimbursement **Retirees and others:** 20% of contracted reimbursement	*Does not apply*
Individual Provider Services[1] Office visits; outpatient office-based medical and surgical care; consultation, diagnosis, and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; rehabilitation services, e.g., physical therapy, speech pathology services, and occupational therapy; medical supplies used within the office, including casts, dressings, and splints.	Per visit: **ADFM:** No copayment **Retirees and others:** $12 copayment	*Same as above*	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** 25% of the maximum allowable charge
Immunizations for Required Overseas Travel Immunizations required for ADFMs whose sponsors have permanent change-of-station orders to overseas locations.	Per Visit: **ADFM:** No copayment **Retirees and others:** Not covered	**ADFM:** 15% of contracted reimbursement **Retirees and others:** Not covered	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** Not covered
Laboratory and X-Ray Services (provided as part of an office visit) [1][2] TRICARE Prime Retirees and others do not have an additional copayment if these services are provided as part of an office visit.	Per visit: **ADFM:** No copayment **Retirees and others:** $12 copayment	**ADFM:** 15% of contracted reimbursement **Retirees and others:** 20% of contracted reimbursement	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** 25% of the maximum allowable charge

**Cost-share is applied after deductible has been satisfied.*

***Benefits under TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) are similar to TRICARE Prime.*

1. *TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.*
2. *If provided as part of an office visit and a copayment is collected for the visit under TRICARE Prime, no additional copayment will be collected for these services.*
3. *Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.*

Inpatient Services (MTF and Civilian Facility)

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
Hospitalization[1][2][3][4] Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and surgical services; meals (including special diets); drugs and medications while an inpatient; operating and recovery room; anesthesia; laboratory tests; X-rays and other radiology services; necessary medical supplies and appliances; and blood and blood products. Unlimited services, as medically necessary.	**ADFM:** MTF: No copayment Civilian: No copayment **Retirees and others:** MTF: $13.32 per day Civilian: $11 per day or $25 minimum charge per admission, whichever is greater. (No separate copayment for separately billed professional charges. Catastrophic Cap protection limits do apply.)	**ADFM:** MTF: $13.32 per day Civilian: $13.32 per day or $25 minimum charge per admission, whichever is greater. **Retirees and others:** MTF: $13.32 per day Civilian: $250 per day or 25% cost-share of the total contracted reimbursement for institutional services, whichever is less, plus 20% cost-share of separately billed professional charges based on the contracted reimbursement.	**ADFM:** MTF: $13.32 per day Civilian care: $13.32 per day or $25 minimum charge per admission, whichever is greater. **Retirees and others:** MTF: $13.32 per day Civilian: $441 per day or 25% cost-share of billed charges, whichever is less, plus 25% cost-share of the maximum allowable charge for separately billed professional charges.
Maternity[1][2][4] Hospital and professional services (prenatal, postnatal). Unlimited services, as medically necessary.	*Same as above*	*Same as above*	*Same as above*
Skilled Nursing Facility (SNF) Care[1][4] Semiprivate room; regular nursing services; meals including special diets; physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances. Unlimited services, as medically necessary.	*Same as above*	*Same as above* Except 20% cost-share of the total contracted reimbursement	**ADFM:** $25 per admission or $13.32 per day, whichever is greater. **Retirees and others:** 25% cost-share of billed charges, plus 25% cost-share of the maximum allowable charge for separately billed professional charges.

** Benefits under TPR and TPRADFM are similar to TRICARE Prime.*

1. *Cost-share and daily inpatient charges are subject to change at the beginning of each fiscal year (October 1–September 30).*
2. *TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.*
3. *TRICARE Standard cost-share for retirees may vary depending on type of treatment or type of hospital.*
4. *Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.*

Hospice Care

Hospice care is available, in lieu of other TRICARE benefits, to provide palliative care to individuals with prognoses of less than six months to live if the terminal illness runs its normal course. Hospice care must be provided by a Medicare-approved program and may include: physician services, nursing care, counseling, inpatient respite care, medical supplies, medications, medical social services, home health aide services, physical and occupational services, speech and language pathology, and short-term acute patient care related to terminal diagnosis.

Note: The individual hospice may charge a cost-share for medications, biologicals, and/or inpatient respite care.

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
Clinical Preventive Examinations Comprehensive-health-promotion and disease-prevention exams for ages 24 months and older. Examinations can include: blood pressure tests; clinical breast exams (high-risk women age 39 and under; annually for all women over 40); pelvic exams (same guideline as Pap smears and should be administered during same visit); clinical testicular exams (annually for high-risk men 13-39); digital rectal exams (annually for high-risk men 40-49; and all men over 50); Prostate Specific Antigen (annually for high-risk men 40-49; men with history of vasectomy at least 20 years previous or at age 40 and over; and all men over 50); oral cavity exams; thyroid palpations; school enrollment physicals ages 5-11 years. ***Note**: Annual sports physicals are not a covered benefit under TRICARE.*	No copayment *Clinical preventive services are an enhanced benefit under TRICARE Prime.*	Applicable cost-share and deductible apply when service is included as part of a cancer screening visit.	Applicable cost-share and deductible apply when service is included as part of a cancer screening visit.
Eye Examinations Clinical preventive service eye exams vary by TRICARE program option (see columns for details of coverage for children and adults). ***Note:** In addition to the clinical preventive service eye exams, ADFMs can receive annual eye exams under normal TRICARE outpatient benefits.* Except for active duty service members (ADSMs), lenses or eyeglasses are only cost-shared for treatment of infantile glaucoma, keratoconus, dry eyes, and irregularities in the shape of the eye.	***For Infants:*** **No copayment** • One eye and vision screening by the beneficiary's PCM during routine exam at birth and 6 months of age. Exam to include screening for visual acuity, ocular alignment, and red reflex along with external examination for ocular abnormalities. ***For Adults and Children Age 3 and over:*** **No copayment** • One comprehensive eye exam by a specialist (ophthalmologist or optometrist) including screening for visual acuity and glaucoma every two years. • Diabetic patients at any age are covered for one comprehensive eye exam yearly.	***For Children:*** **Covered under Well-Child Care benefit.** Applicable cost-share and deductible apply. • One eye and vision screening by a TRICARE network provider during routine exam at birth and 6 months of age. • Two comprehensive eye exams by specialist (ophthalmologist or optometrist) for amblyopia (vision loss) and strabismus (cross eye) between 3-6 years of age. ***For Adults:*** Not covered	***For Children:*** **Covered under Well-Child Care benefit.** Applicable cost-share and deductible apply. • One eye and vision screening by a TRICARE network provider during routine exam at birth and 6 months of age. • Two comprehensive eye exams by specialist (ophthalmologist or optometrist) for amblyopia (vision loss) and strabismus (cross eye) between 3-6 years of age. ***For Adults:*** Not covered

**TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.*

Clinical Preventive Services (continued)

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
Immunizations Age appropriate doses of vaccines recommended and adopted by the Center for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP). Refer to CDC's homepage (www.cdc.gov) for a current schedule of recommended vaccines. *Immunizations for Overseas Travel: See information listed in the Outpatient Services Outside of the MTF section of these charts.*	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.
Patient and Parent Education or Counseling Services The following education or counseling services are covered when included as part of an office visit: dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol, and substance abuse; accident and injury prevention; promoting dental health; stress, bereavement, and suicide risk assessment.	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.
Periodic Screening Examinations Beneficiaries will be offered age- and gender-appropriate screening tests for the early detection of disease and/or disease risk factors, including: **Cancer Screening:** Annual screening mammograms for women over the age of 39, (for high-risk baseline at 35 years, then annually); Pap smears (see below); proctosigmoidoscopy or sigmoidoscopy (once every 3-5 years beginning at age 50); colonoscopy (every 2 years beginning at age 25 or 5 years younger than the earliest age of diagnosis for colon rectal cancer, whichever is earlier, and then annually after age 40 for individuals with hereditary non-polyposis colon rectal cancer syndrome. Individuals with familial risk of sporadic colon rectal cancer (i.e. individuals with first degree relatives with sporadic colon rectal cancer or adenomas before the age of 60 or multiple first degree relatives with colon rectal cancer or adenomas) may receive a colonoscopy every 3 to 5 years beginning at age 10 years earlier than the youngest affected relative), and fecal occult blood testing (annually age 50 and above); skin cancer exams (for high-risk individuals with family history or increased exposure to sunlight)	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.

**TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.*

Clinical Preventive Services (continued)

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
Routine Pap Smears: Annually starting at age 18 (or younger if sexually active) until three consecutive satisfactorily normal annual examinations. Frequency may be less often at the discretion of the patient and the clinician, but not less than every three years. **Infectious Disease Screening:** Screening for Hepatitis B, Rubella antibodies, and HIV and screening and/or prophylaxis for tetanus, rabies, Rh immune globulin, Hepatitis A&B, meningococcal meningitis, and tuberculosis **Cardiovascular:** Cholesterol (once every 5 years beginning at age 18) and blood pressure (children: annually between ages 3-6 and every 2 years thereafter; adults: minimum every 2 years) **Hearing:** Preventive hearing screenings for all high risk neonates as defined by the Joint Committee on Infant Hearing. A newborn audiology screening should be performed on high-risk newborns prior to hospital discharge or within the first three months. Evaluative hearing tests may be performed at other ages during routine exams. **Other:** Assessment of risk for lead exposure by structured questionnaire (during each Well-Child Care visit from 6 months to 6 years); blood lead test for all children determined to be high-risk	No copayment	Applicable cost-share and deductible apply when service is included as part of a cancer screening visit.	Applicable cost-share and deductible apply when service is included as part of a cancer screening visit.
Well-Child Care Well-Child Care (birth to 6 years) includes routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight, and head circumference; routine immunizations; and developmental and behavioral appraisal in accordance with the American Academy of Pediatrics (AAP) and CDC guidelines.	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.

**TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.*

U.S. Preventive Services Task Force

The U.S. Preventive Services Task Force and other major authorities recommend that a clinical preventive examination be used for early detection of disease. This provides prompt treatment and encourages healthy lifestyles. A TRICARE-covered clinical preventive examination is performed periodically and includes the following:

- Risk assessment
- Physical examination
- Laboratory tests
- X-rays
- Risk-specific counseling allowing for prevention, early detection, and treatment of diseases before they manifest themselves as major health problems

A network provider must perform a clinical preventive examination for a TRICARE Prime beneficiary. A TRICARE Standard beneficiary may have clinical preventive examinations performed by a network or certified non-network provider. As depicted in the chart on the previous page, TRICARE Extra and TRICARE Standard beneficiaries do not have the same clinical preventive services as TRICARE Prime beneficiaries.

Routine Physical Examinations

TRICARE benefits are different for routine physical examinations than for clinical preventive examinations. Routine physical examinations are not a TRICARE-covered benefit. TRICARE considers a routine physical examination to be an evaluation of the general health of adults and children conducted in the absence of a presenting complaint or other indication of illness or injury.

When required by the uniformed services, claims may be covered for physical examinations provided for family members traveling outside of the U.S. as a result of their sponsoring active duty service member's assignment. Such claims must be accompanied by documentation indicating the ADSM's overseas assignment.

Emergency and Urgent Care

Urgent Care

Urgent care services are medically necessary services which are required for illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have 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.

Emergency Services

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. In all emergency situations, the TRICARE Prime beneficiary must notify his/her PCM or TriWest of any emergency admission within 24 hours so that ongoing care can be coordinated.

Emergency care is covered for medical, maternity, or psychiatric emergencies that would lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe that a serious medical condition existed or that the absence of medical attention would result in a threat to life, limb, or sight, or that the person may be a danger to self or others and requires immediate medical treatment or manifests painful symptoms requiring immediate palliative effort to relieve suffering. This includes situations where a beneficiary arrives at the emergency room with severe pain. In the case of a pregnant woman, the danger to the health of the woman or her unborn child should be considered.

Limitations and Exclusions

Below you will find a list of medical/surgical services generally not covered under TRICARE. The items here are not intended to be all-inclusive. Contact TriWest or visit their Web site for more information.

Services or Procedures with Significant Limitations

Abortions—Abortions are only covered when the mother's life is in danger. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided.

Cardiac and Pulmonary Rehabilitation—Both are only covered for non-hospital based cardiac rehabilitation programs and phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically supervised settings.

Chiropractic Care—Coverage is limited to active duty service members and is only available at specific military treatment facilities under the Chiropractic Care Program. Visit the TRICARE Web site at www.tricare.osd.mil/chiropractic for more information.

Cosmetic, Plastic, or Reconstructive Surgery—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 breast reconstruction after cancer surgery.

Cranial Orthotic Device or Molding Helmet—Cranial orthotic devices are excluded for treatment of nonsynostic positional plagiocephaly.

Dental Care and Dental X-Rays—Both are covered only for adjunctive dental care.

Dental Anesthesia and Facility Charges—Covered only to safeguard a patient's life.

Education and Training—Education and training are only covered under the PFPWD and diabetic outpatient self-management training services (HCPCS G0108 and G0109 codes must be accompanied with a "Certificate of Recognition" from the ADA.)

Eyeglasses or Contact Lenses—Both are covered under limited circumstances, such as corneal lens removal.

Food, Food Substitutes or Supplements, or Vitamins Outside of a Hospital Setting—Covered only for home enteral or parenteral nutrition therapy, such as prescribed for cancer patients.

Gastric Bypass—To be covered, you must be 100 pounds over ideal body weight and have a co-morbidity or 200 percent of ideal body weight with no co-morbidity.

Genetic Testing—Genetic testing is only covered under certain conditions.

Hearing Aids—Hearing aids are covered under the PFPWD.

Exclusions

The following services are excluded under any circumstance:

- Acupuncture
- Artificial insemination
- Autopsy services or post-mortem examinations
- Birth control (non-prescription)
- Bone marrow transplants for treatment of ovarian cancer
- Camps
- Care or supplies furnished or prescribed by an immediate family member
- Naturopaths
- Diagnostic admission
- Experimental or unproven procedures
- Foot care (routine)
- Laser/LASIK/Refractive corneal surgery
- Learning disabilities

An explanation of covered behavioral services and how to manage and document care

Behavioral Health Care Services

This section will assist you with specific behavioral health aspects of the TRICARE program.

TRICARE beneficiaries are encouraged to receive behavioral health care from a military treatment facility (MTF). However, access may be limited due to space-availability issues or the MTF's ability to render the care needed. When a service is not available at an MTF, beneficiaries may seek behavioral health care from a certified and preferably network provider.

Covered Behavioral Health Services

Outpatient Services

Behavioral health care received from a mental health counselor or licensed professional counselor (LPC) requires a physician referral and supervision. TRICARE Prime beneficiaries may self-refer to a network provider without a primary care manager (PCM) referral. Upon the first visit, providers can contact TriWest through the provider service line at 1-888-TRIWEST (1-888-874-9378) for eligibility verification or other questions.

For specialized outpatient services, providers must submit a request by fax to 1-888-212-1768 or by mail to the address below. Your request will be reviewed to determine whether continuing care meets InterQual criteria. No additional sessions are authorized until the treatment request is reviewed.

Mailed requests should be sent to:

TriWest Healthcare Alliance
Prior Authorizations
P.O. Box 42049
Phoenix, AZ 85080-2049

Psychiatric Diagnostic Interview Examination (90801)

Each provider will be allowed one 90801 session per beneficiary per year without authorization. If a provider needs more than one 90801 session within the same benefit period, authorization must be requested using the "Outpatient Treatment Request" form. The benefit year for TRICARE Prime, TRICARE Standard, and TRICARE Extra is based on the fiscal year (October 1–September 30).

Outpatient Psychotherapy

Outpatient psychotherapy is a TRICARE-authorized benefit when it is determined to be medically or psychologically necessary for treatment of a behavioral health disorder. The following services are available for outpatient psychotherapy:

- Individual psychotherapy
- Group or conjoint (up to 90 minutes)
- Crisis intervention (up to 75–80 minutes)
- Collateral visits
- Family therapy (up to 90 minutes)
- Psychoanalysis

Note: Routine services exclude treatment such as psychoanalysis, electroconvulsive therapy (ECT), intensive outpatient programs (IOP), psychological testing and higher intensity levels of the services listed above. These services are subject to review and prior authorization.

The following frequency limitations apply to outpatient psychotherapy:

- A provider cannot bill for more than two sessions per calendar week (Sunday–Saturday) without pre-authorization.
- Two psychotherapy sessions may not be combined (e.g., 30 minutes on one day may not be added to 20 minutes on another day and counted as one session) to circumvent the frequency limitation criteria.

- 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 the beneficiary receives individual therapy.

Psychological and Neuropsychological Testing

Psychological and neuropsychological testing are generally limited to six hours in a fiscal year. However, additional hours may be approved on a case-by-case basis. The testing must be medically necessary 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 and neuropsychological testing always require pre-authorization, regardless of the setting (inpatient or outpatient). A "Pre-authorization for Psychological Testing" form must be submitted for authorization. When completing the form, a provider may request an initial evaluation in conjunction with testing not included within the initial eight sessions. The following psychological and neuropsychological testing is not covered under TRICARE:

- Reitan-Indiana battery when administered to beneficiaries under age 5 or self-administered to beneficiaries under age 13
- Assessment for academic placement, including all psychological testing related to educational programs, issues, or deficiencies
- Testing to determine a learning disability, if the primary or sole basis for the testing is to assess for a learning disability
- Testing in conjunction with child custody disputes
- Testing in conjunction with job placement
- General screening (in the absence of specific symptoms of a covered behavioral health disorder) to determine if individuals being tested are suffering from a behavioral health disorder
- Teacher or parental referrals for psychological testing
- Diagnosing specific learning disorders or learning disabilities encompassing a reading disorder (e.g., dyslexia), mathematics disorder, disorder of written expression, or learning disorder not otherwise specified

Medication Management

Medication management is covered when provided as an independent procedure and rendered by a TRICARE-authorized provider. TRICARE pays for up to two medication management visits per month without a pre-authorization. Medication management sessions exceeding two visits per month must be pre-authorized.

Note: When a provider is performing medication management along with therapy (procedure codes 90805, 90807, and 90809), a pre-authorization is required. The provider must submit an "Outpatient Treatment Request" form to TriWest to obtain this pre-authorization.

Intensive Outpatient Program

The Intensive Outpatient Program (IOP) offers a great diversity of treatment options for beneficiaries requiring more than the TRICARE-allowed behavioral health benefit, but not the services of inpatient or partial hospitalization programs (PHP). IOPs are for both adults and children, allowing the outpatient provider the flexibility to establish an individual treatment plan for each beneficiary that can include any combination of individual, group, or family therapy, medication management, outreach, or brief case management. IOP services require pre-authorization.

To qualify as a TRICARE IOP provider, the facility must be affiliated with a TRICARE-approved inpatient psychiatric institution. Depending on the beneficiary's needs, multiple levels of intensive outpatient care may be required. The beneficiary's cost-share/copayment for an IOP session (each day the beneficiary attends the IOP) is the same as for group therapy.

Electroconvulsive Therapy

Electroconvulsive Therapy (ECT) is a TRICARE-authorized benefit when determined to be medically necessary. To be considered for payment, providers must request pre-authorization for all ECT components (the facility, the psychiatrist, and the anesthesiologist). A "Request for ECT" form must be submitted to TriWest for authorization.

Inpatient Services

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."

TriWest's Crisis Line is available 24 hours per day, seven days per week to offer assistance with psychiatric emergency cases. The TriWest Crisis Line is 1-888-TRIWEST (1-888-874-9378). Providers are encouraged to publish this number to their beneficiaries. 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 fiscal year (October 1–September 30). The range is as follows:

- 30 days for beneficiaries 19 and older
- 45 days for beneficiaries 18 and younger

An inpatient admission for substance abuse detoxification and rehabilitation counts toward the 30–45 day per fiscal year limit for inpatient behavioral health services, regardless of whether the beneficiary is admitted to a general hospital or substance abuse disorder rehabilitation facility.

Authorization

Pre-authorization is required for all behavioral health admissions without exception. Pre-authorization is required for all non-emergent admissions. Admissions resulting from a psychiatric emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to TriWest within 72 hours of the admission. TriWest will conduct a concurrent review for continuation of inpatient mental health services within 72 hours of emergency admissions and authorize additional days, as appropriate.

Discharge Planning

Discharge planning is an important function that facilitates the transition of the beneficiary into a less-restrictive level of care. Behavioral health providers are expected to make discharge planning a routine part of treatment. As part of the concurrent review process, the TriWest Utilization Management (UM) staff reviews the discharge plan with the provider and assists the provider in identifying available resources within the admitting facility, the community, and the network.

Aftercare Planning

Aftercare planning is thorough and unique to each case. As part of the process, the TriWest UM department reviews the treatment plan and aftercare planning with the treating clinician every few days. The provider updates the treatment plan as appropriate to help ensure that there is a record of the beneficiary's progress through the continuum of care. As the time for discharge from the inpatient setting approaches, the aftercare plan becomes more concrete and the next level of care is identified (e.g., partial hospitalization, outpatient therapy). At this point, the specific provider of the next level of care is identified and the first appointment is scheduled.

During the concurrent review, the facility's utilization review clinician must notify the TriWest case manager of the beneficiary's

discharge date, discharge diagnosis, discharge medications, and aftercare plans, including the date of the first scheduled outpatient appointment.

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 a separate payment for inpatient psychotherapy.

Alcoholism and Other Substance Abuse Disorders

Treatment includes the following:

Hospital Care

TRICARE helps pay for up to seven days of detoxification in a TRICARE-certified substance use disorder rehabilitation facility. Hospital care may be needed when the patient suffers from delirium, confusion, trauma, unconsciousness, or malnutrition. The seven-day detoxification is included in the maximum of 30 or 45 days (depending on the patient's age) of inpatient mental health care allowed per fiscal year. This seven-day period does not count toward the 21 days of rehabilitation mentioned below.

Rehabilitation Stays

In addition to the seven-day detoxification period mentioned above, TRICARE helps pay for up to 21 days of rehabilitation (this 21-day rehabilitation is included in the 30 or 45 days of inpatient mental health care allowed per fiscal year, but beneficiaries are limited to 21 days per 365-day period and three inpatient admissions during the person's life). Rehabilitation stays are covered only in a hospital or special treatment center whose alcohol or other substance use disorder rehabilitation facility has entered into a participation agreement with TRICARE and has been identified as a TRICARE-certified facility.

Treatment for alcoholism or other substance use disorders includes "partial hospitalization" in a TRICARE-certified substance use disorder rehabilitation facility. Partial hospitalization is treatment where the patient spends at least three hours a day, five days a week at the facility (the treatment may also occur during weekends or evenings), but then goes home at night. TRICARE shares the cost of this treatment up to 21 days at a predetermined, all-inclusive *per diem* rate.

Outpatient Care for Alcoholism or Other Substance Use Disorders

TRICARE provides coverage for up to 60 visits over the course of a "benefit year," beginning the first day of the rehabilitation phase of treatment. Family therapy is covered for up to 15 visits per year, beginning the first day of therapy. These services are covered only in a hospital or special treatment center whose alcohol or other substance use disorder rehabilitation facility has entered into a participation agreement with TRICARE and has been identified as a TRICARE-certified facility. Outpatient care is covered in a group setting only. Individual outpatient care is not a covered benefit.

Waivers to the limits on care can be granted if the continued care meets certain requirements. This is true of both inpatient care and partial hospitalization.

Residential Treatment Centers

Residential Treatment Centers (RTCs) provide treatment for adolescents (up to age 21) who require behavioral health care due to a serious behavioral health disorder. Children who only have disciplinary problems do not qualify for treatment in an RTC setting. All RTCs must be TRICARE-certified by the Colorado Foundation of Medical Care to provide residential treatment to TRICARE-eligible beneficiaries. The specific duration limit is a maximum of 150 days in a fiscal year (October 1–September 30) or for a single admission. These limits are subject to waiver in certain cases.

Pre-authorization

Authorization is always required before a beneficiary is admitted to an RTC. Documentation must be submitted to support each request. A psychiatrist or other physician must recommend that the child be admitted to the RTC, and a psychiatrist or clinical psychologist must direct the development of a treatment plan. The behavioral health disorder must meet clinical review criteria before admission can be authorized. In addition, concurrent reviews are conducted during the course of the RTC stay.

Reimbursement

TRICARE reimbursement for RTC care is an all-inclusive per diem rate. There are only two charges considered outside the all-inclusive RTC rate. The charges outside the all-inclusive RTC rate are defined below:

- Geographically distant family therapy—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. TriWest must pre-authorize all geographically distant family therapy.
- 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 payer of last resort. For network providers, this coverage limitation applies only if educational services are not part of the contracted per diem rate.

Psychiatric Partial Hospitalization Programs

A psychiatric partial hospitalization program (PHP) provides an appropriate setting for crisis stabilization or treatment of partially stabilized behavioral health disorders. It also serves as a transition from an inpatient program when medically necessary. All psychiatric hospitalization programs must be TRICARE-certified by the Colorado Foundation of Medical Care in order to provide partial hospitalization care to TRICARE-eligible beneficiaries. Additionally, psychiatric PHP facilities must be capable of providing an interdisciplinary program of medically therapeutic services at least three hours per day, up to five days per week. This can include day, evening, or weekend treatment.

The TRICARE benefit for psychiatric PHP is limited to a maximum of 60 treatment days (whether a full- or half-day program) in a fiscal year (October 1–September 30) or for any single admission. The limit may be waived if the treatment is determined to be medically necessary. The 60 PHP treatment days are not offset by, nor counted toward, the inpatient limit of 30 days for beneficiaries age 19 years and older or 45 days for beneficiaries age 18 years and younger. Substance abuse partial hospitalization days will count toward the maximum 60 psychiatric partial hospitalization days.

Pre-authorization

Pre-authorization is required for all PHPs, without exception. The facility must submit sufficient documentation to support the services. Concurrent reviews are conducted during the course of the stay.

Reimbursement

Psychological testing conducted while a beneficiary is in an approved PHP will be considered included in the facility's per diem rate. PHP care must be billed on a UB-92.

Court-ordered Care

Court-ordered care is defined by TRICARE as medical services, including inpatient admissions, that a party in a legal proceeding is ordered or directed to obtain by a court of law. The fact that behavioral health 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. The services must be at the appropriate level of care to treat the condition, and the beneficiary (or family) must have a legal delegation to pay for the services.

Non-covered Behavioral Health Services

The following behavioral health services are not covered under TRICARE:

- Environmental ecological treatments
- Megavitamin or orthomolecular therapy
- Transcendental meditation
- Rolfing
- Z therapy
- Primal therapy
- Bioenergetic therapy
- Carbon dioxide therapy
- Guided imagery
- Sedative action electrostimulation therapy
- Aversion therapy (including electric shock and the use of chemicals for alcoholism)
- Narcotherapy with LSD
- Marathon therapy
- Hemodialysis for schizophrenia
- Training analysis
- Tilial therapy
- Sexual dysfunction therapy
- Eye movement debriefing response
- 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.)
- Behavioral health services and supplies related solely to obesity and/or weight reduction
- Biofeedback for psychosomatic conditions
- Counseling services, such as nutritional counseling, stress management, marriage counseling, or lifestyle modifications
- Custodial nursing care
- V-Codes
- Experimental procedures
- Educational programs
- Smoking cessation programs
- Therapy for developmental disorders, such as dyslexia, developmental mathematics disorders, developmental language disorders, and developmental articulation disorders

Sexual Disorders

Sexual dysfunction is characterized by disturbances in sexual desire and the psychophysiological changes that characterize the sexual response cycle. 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:

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

Behavioral Health Care Management

- For information about claims processing and billing, refer to section entitled "Claims Processing and Billing Information."
- For information about case management, refer to the section entitled "Health Care Management and Administration."
- For information about provider credentialing and contracting, refer to the section entitled "Important Provider Information."

Behavioral Health Medical Record Documentation

The following information should be included in each individual beneficiary record.

Note: 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
- Appropriate discharge planning
- Legible provider name(s)/signature(s)

Inpatient Medical Record Documentation for Behavioral Health Services

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 exam within 24 hours of admission (**Note:** The complete report must be documented within 72 hours of acute and RTC programs and within three working days for PHP.)
- 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 days for full-day PHPs, and seven days for half-day PHPs
- Family assessment report within 72 hours of admission for acute care and within seven 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 Record Documentation for Behavioral Health Services

The individual provider (office) medical record must include the beneficiary's:

- Address
- Employer and/or school name(s)
- Home and alternative telephone numbers
- Guardianship information, if applicable
- Marital/legal status
- The address and telephone number of at least one designated emergency contact

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 should contain a signed Patient Bill of Rights, as well as documentation showing communication with the beneficiary's primary physician.

Initial Evaluation for Behavioral Health Services

The medical record of the beneficiary's initial evaluation should 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 information on the beneficiary's:

- 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

An appropriately detailed psychosocial history should include items about family, educational, occupational, relevant legal, 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 medications and other substances (**Note:** 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
- Information about the presence or absence of allergies and sensitivities to pharmaceuticals and other substances
- A completed substance abuse evaluation for beneficiaries ages 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)
- A five-axis Diagnostic and Statistical Manual for Mental Disorders, Volume IV (DSM-IV) diagnosis consistent with the presenting problem(s), history, mental status examination, and other assessment data
- Documentation that a follow-up appointment has been scheduled

Treatment Plan for Behavioral Health Services

The treatment plan's documentation should make clear the relationship between the diagnosis/case formulation and the treatment plan. The treatment plan must include:

- Objective, measurable goals
- Estimated time frames for goal attainment or problem resolution
- Evidence of the beneficiary's understanding of the treatment plan

Progress Noted in Treatment for Behavioral Health Services

Progress notes must 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 should include:

- Documentation that all concurrent relevant caregivers (e.g., consultants, primary physicians, ancillary practitioners, and health care institutions) are contacted or involved in treatment and show evidence of continuity and coordination of care (**Note:** Please 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 five-axis DSM-IV diagnosis
    - 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 feeling of goals being achieved/not achieved

Medication Management Records for Behavioral Health Services

To adhere to TRICARE procedures and requirements, medication management records should 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 abuse/dependency

Outside Resources Documentation for Behavioral Health Services

If outside resources are utilized for care, the following documentation must be included:

- Documentation of the utilization 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

Notes

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Notes

Roles, responsibilities, and procedural information for operating as a TRICARE provider

Referrals and Authorizations

When a TRICARE Prime beneficiary's primary care manager (PCM) is unable to provide a specialized medical service, the PCM must contact TriWest to request a referral. TriWest issues a referral when a TRICARE Prime beneficiary needs specialized medical services from a professional or ancillary provider only if services are not available at the military treatment facility (MTF). **The MTF is always the primary source of care for TRICARE beneficiaries.** The MTF has first "right of refusal" to provide care for a TRICARE beneficiary. Requests for a referral can be obtained by either submitting a HIPAA-Compliant 278 (electronic transmission) or faxing a referral to TriWest with the following information:

- Sponsor's social security number (SSN)
- Sponsor's name
- Beneficiary's name
- Beneficiary's date of birth
- Beneficiary's address and telephone number
- Type of service requested (e.g., consultation only, evaluation and treatment, admission, outpatient procedure)
- Diagnosis and diagnosis code
- Procedure(s) requested and procedure code(s)
- Date of service
- Urgency of request
- Facility name, tax identification (ID) number, address, telephone and fax numbers
- PCM's tax ID number, name, address, telephone and fax numbers
- Specialist's tax ID number, name, address, telephone and fax numbers

TriWest staff reviews referral requests in order to:

- Determine the beneficiary's TRICARE eligibility
- Verify that the service requested is a TRICARE benefit
- Determine if the service requested can be provided by an MTF and send the beneficiary to the MTF if available
- Locate a network civilian provider (if a network provider cannot be located, a non-network provider may be authorized)
- Notify the beneficiary and the provider that the referral has been completed

Referral and Appointment Process

The beneficiary will be notified via letter with the information needed to schedule his/her own appointment with the specialist. The letter is mailed within one business day and includes the following information:

- Referral number
- Specialist's name and contact information
- Office address
- Office telephone number
- Time frame in which the appointment must be scheduled by the beneficiary
- Instructions to call TriWest's Interactive Voice Response (IVR) system to "activate the referral"

A referral is valid for 60 calendar days from the date of issuance 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 an approval number can be issued. Additionally, a copy of the approved referral and beneficiary information is sent by fax to the specialist's office. The TriWest staff can assist in this process and answer any questions providers may have. Visit www.triwest.com or call 1-888-TRIWEST (1-888-874-9378).

Referral Extensions

A specialist who determines that additional or continued care is required needs to communicate, either in writing or verbally, with the referring

provider (civilian or MTF) and TriWest. This process gives the referring provider an opportunity for input regarding the continuity of care.

If an MTF referring provider determines that the additional care can be provided at the MTF, the beneficiary will receive the care at the MTF. If it is determined that the specialty services needed are not available at the MTF, the MTF must contact TriWest at 1-888-TRIWEST (1-888-874-9378) to request a new approval. TriWest determines whether the referral can be completed or if additional information is required. Network providers must be utilized if available. Non-network providers will not be authorized without review.

Report Tracking

The TRICARE West Region contract requires providers to submit their specialist reports (consultation reports, discharge summaries, operatives reports, etc.) to the referring provider within 10 working days of the appointment date. Refer to section entitled "Important Provider Information" for more details.

Prior Authorizations

An authorization is issued 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.

Providers serving TRICARE Standard beneficiaries are required to obtain authorization before performing procedures on the medical necessity review list. Network providers should contact their local network representative for a copy of the medical necessity review list. Non-network providers should contact their TRICARE field representative at 1-888-TRIWEST (1-888-874-9378). Pre-authorization from TRICARE is **not** required when the beneficiary has other health insurance (OHI) that covers the treatment required, **except** in the case of adjunctive dental care, transplants, and behavioral health care services.

The following guidelines will help expedite an authorization request:

- Be specific about the requested services. Provide the most appropriate procedure and diagnosis codes.
- Submit request forms with physician documentation and all clinical indications, including laboratory/radiology results, related to the requested service.
- Mail pictures needed to support the requested service to TriWest. Pictures sent via fax do not transmit clearly and may delay the process while TriWest requests and awaits receipt of originals.
- Report any change in services connected with active approvals immediately to TriWest's Utilization Management department to avoid claim denials. Visit www.triwest.com or call 1-888-TRIWEST (1-888-874-9378). Generally, approvals are active for 60 days.
- Verify the beneficiary's demographic information (sponsor's SSN, address, etc.) and include it on the request form. This information will help expedite the verification and approval process.

Note: Prior authorization is **not** a guarantee of payment.

Penalties for Non-compliance

Network Providers

TRICARE claims submitted to Wisconsin Physicians Service (WPS) without the required authorization are reimbursed at the allowable amount 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 can request a post-service, prepayment review from WPS. Requests for review should be sent, along with documentation, to WPS's address listed below.

Wisconsin Physicians Service (WPS)
P. O. Box 77028
Madison, WI 53707-7028

Non-network Providers

TRICARE claims submitted to WPS 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. All TRICARE providers in nonemergency settings are required to obtain an authorization for procedures included on the medical necessity review list. Network providers should contact their local network representative for a copy of the medical necessity review list. Non-network providers should contact their TRICARE field representative at 1-888-TRIWEST (1-888-874-9378). All providers may access the medical necessity review list at www.triwest.com. If an authorization has already been obtained for a hospital stay, a second authorization for a procedure on this list is **not required**.

The medical necessity review list is subject to change annually. Providers are notified of changes to this list via publications and provider seminars.

Referrals and authorizations **are not** required for TRICARE-covered procedures when the beneficiary has OHI that covers the rendered service, except in cases of behavioral health treatment, transplants, and adjunctive dental care. Even if OHI is involved, authorization is required for **any** behavioral health treatment outside of the initial eight self-referred visits. See section entitled "Behavioral Health Care Services" 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.
- Uniformed services members receiving care under the TRICARE Prime Remote program or the Supplemental Health Care Program (see section entitled "TRICARE Program Options") are not subject to coordination-of-benefit rules.
- For a Skilled Nursing Facility admission, TriWest must be notified.

See section entitled "Claims Processing and Billing Information" for more information about coordinating benefits between TRICARE and OHI. TRICARE is always the primary payer for active duty service members.

Out of Region Care

TRICARE Prime beneficiaries must still contact their PCM first for all nonemergency care while traveling outside the West Region area. In the case of an emergency, TRICARE Prime beneficiaries should obtain the required services but also contact their PCM as soon as possible after the emergency care is received.

Medical Records Documentation

TriWest may review providers' clinical 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 medical record is appropriately organized and that confidentiality of the beneficiary's information is maintained. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

The following guidelines will assist you in documenting medical and surgical care in every individual patient record:

- The record must be legible to someone other than the writer.
- Every page in the record must contain the beneficiary's name or identification (ID) number.
- Personal/biographic data should include address, employer, home and work telephone numbers, and marital status.
- All entries in the medical record should 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.
- Past medical history (for beneficiaries seen three or more times) should be easily identifiable and include serious accidents, operations, and illnesses.
- For children and adolescents (18 years and younger), past medical history should relate to prenatal care, birth, operations, and childhood illnesses.
- For beneficiaries 14 years and older who have been seen three or more times, information concerning use/abuse of cigarettes, alcohol, and controlled substances should be noted.
- The history and physical should be done no more than seven days before, or 48 hours after, admission by a doctor of medicine or osteopathy, or by an oromaxillofacial surgeon who has been granted such privileges by the medical staff, in accordance with state law. If a history and physical examination has been performed within 30 days, but greater than seven days before admission, any changes must be described in the physician's admission note.
- 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 have 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 should 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
    - Time of administration
    - Dosage
    - Route of administration
    - Site of injection
    - Signature or initials of individual administering the medication

Note: For immunizations, the 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 must also be documented.

Utilization Review

Utilization Review is a process that manages the beneficiary at the point-of-care through prospective review, concurrent review, and retrospective review.

Prospective Review

Prospective review is conducted when a certain procedure or service requires a medical necessity review. The review is performed under the direction of a registered nurse, 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: Initial reviewers cannot deny services but must refer liable cases to second-level review. Physician and/or peer reviewers perform second-level reviews.

Concurrent Review

Concurrent review is a process of continual reassessment of the beneficiary's needs during an inpatient stay. Concurrent review activities monitor the patient for appropriate level of care and identify potential care coordination, disease-management/demand-management, discharge needs, and case-management candidates.

The care coordinator responsible for concurrent review evaluates the beneficiary's level-of-care needs during hospitalization. Based on medical determinations of levels of assistance that may be required, an entire episode of medical care may be adapted to fit the beneficiary's status and needs. Components may include:

- A continuum of health care based on identified needs and goals
- Design and adaptation of health care initiatives for the beneficiary
- Identification of assistance needs throughout an entire episode of care
- Beneficiary and family education

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.

Care Coordination

Care coordination is a comprehensive method of client assessment, designed to identify client vulnerability, needs, and goals, that results in the development of an action plan to produce an outcome that is desirous for the client. The goal is to provide client advocacy, a system for coordinating client services, and a systematic approach to evaluation of the effectiveness of the client's health maintenance.

TRICARE West Region Care Coordination identifies and assists TRICARE beneficiaries with post-service needs.

Clinical pathways and practice guidelines are used as tools to facilitate the care coordination process. The care coordination process is monitored through concurrent review activities, which assess and identify potential care coordination, disease-management/demand-management, and discharge needs and case-management candidates.

Providers can access care coordination for beneficiaries in two ways, either through concurrent review nurses or through a case-management referral. Visit www.triwest.com or call 1-888-TRIWEST (1-888-874-9378).

Case Management

Case management and care coordination share the same collaborative approach to meeting the health care needs of the beneficiary. Case management provides an integrated approach to managing the complex health care needs of an eligible beneficiary. This may include care coordination, behavioral health, and the catastrophic case management models. The case management department also administers specialty programs, such as the DoD/National Cancer Institute Demonstration Program, the TRICARE Extended Care Health Option, 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. TriWest case managers act as beneficiary advocates, working with multidisciplinary teams utilizing clinical skills and knowledge to help ensure that the best possible care is provided. Beneficiaries who have complex, catastrophic and short-term and/or long-term 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 TriWest. An MTF or a member of TriWest's staff can also refer beneficiaries to case management. When a beneficiary is in case management, his/her case manager may provide multiple services, including:

- Identifying and facilitating needed services and equipment, in collaboration with the primary care manager, for optimal health care delivery
- 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/her disease process and promoting lifestyle changes that can positively affect the management of the disease (e.g., diet, exercise, compliance with the recommended treatment plan, stress management, and keeping physician appointments)
- Providing a point of contact to assist with problem solving, act as a beneficiary advocate, and assist in communicating with caregivers on behalf of the beneficiary

The following catastrophic conditions must be reported to TriWest at 1-888-TRIWEST (1-888-874-9378) within 24 hours of diagnosis; within 24 hours of admission to any acute care facility; or by the business day following admission.

- Head trauma
- Spinal cord injuries
- Acute HIV/AIDS
- Neoplasms and malignancy
- All admissions to a neonatal intensive care unit
- Bone marrow procedures
- Transplant and dialysis procedures
- Burns (3rd degree or extensive 2nd degree)
- Obstetrical conditions that require hospitalization prior to delivery
- Previous history of intensive care for an infant
- Expected multiple birth
- Neurological conditions involving intensive care or unconsciousness for more than 48 hours
- Cardiovascular conditions
- Respiratory dependency conditions

National Quality Monitoring Contractor

Maximus Inc., of Reston, Va., is the TRICARE National Quality Monitoring Contractor (NQMC) and will assist DoD Health Affairs, TRICARE Management Activity (TMA), MTF market managers, and the new TRICARE Regional Offices by providing the government with an independent, impartial evaluation of the care provided to beneficiaries within the Military Health System. The NQMC will review care provided by TriWest network providers in addition to other TRICARE contractors and subcontractors on a limited basis. The NQMC is part of TRICARE's Quality and Utilization Peer Review Organization program, in accordance with 32 CFR 199.15.

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 pre-payment control system, the post-payment evaluation system, quality assurance activities, reports from beneficiaries, and identification by a provider's employees or TriWest staff.

The TMA has a specific office to oversee the fraud and abuse program for TRICARE. The Program Integrity Branch analyzes and reviews cases of potential fraud (intent to deceive or misrepresent to secure unlawful gain). Some examples of fraud are as follows:

- Billing for services, supplies, or equipment not furnished or used by the beneficiary
- Billing for costs of non-covered or non-chargeable services, supplies, or equipment disguised as covered items
- Violation of the participation agreement that results in the beneficiary being billed for amounts that exceed the TRICARE allowable charge or contracted rate
- Duplicate billings, i.e., 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
- Reciprocal billing, i.e., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed
- Practicing with an expired or revoked license, since an expired or revoked license in any state or territory of the U.S. will result in a loss of authorized provider status under TRICARE
- Agreements or arrangements between the provider and the beneficiary that result in billings or claims for unnecessary costs or charges to TRICARE

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

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

Providers are cautioned that unbundling, fragmenting, or code gaming to manipulate the Physicians’ Current Procedural Terminology (CPT) codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such a 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 an authorized provider. The TMA Office of General Counsel works in conjunction with the Program Integrity Branch in dealing with fraud and abuse. The DoD Inspector General and other agencies investigate TRICARE fraud.

To report suspected fraud and/or abuse, call the TriWest Fraud Hotline at 1-888-584-9378.

Grievances

If a provider or beneficiary has a concern about the level or quality of services (or care) received through the TRICARE program, he/she has a right to file a grievance with TriWest.

A grievance is a written complaint on a non-appealable issue that deals primarily with a perceived failure of a network provider or an employee of TriWest or its subcontractor(s) to furnish the level or quality of service or care expected by a beneficiary or provider. The following are examples of issues subject to the grievance process:

- Complaints concerning the quality of a clinical or non-clinical service received by a beneficiary
- Complaints regarding wait times in a provider’s office, physician or employee behavior, adequacy of facilities, and other similar concerns

- Complaints about the level of customer service provided by a provider, contractor, or subcontractor staff

Grievances received by TriWest 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:

TriWest Healthcare Alliance
Attn: Customer Relations
P. O. Box 42049
Phoenix, AZ 85080

Grievances may also be submitted by fax to 1-602-564-2523 to the attention of the Customer Relations department. This fax machine is located in a secure location within the Customer Relations department, and confidentiality can be assured.

TriWest reviews the grievance and provides a response within 30 calendar days from the date the grievance is received. 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/she may request an appeal of the review decision in writing.

Appeals

TRICARE beneficiaries and non-network participating providers have the right to appeal decisions made by TMA or TriWest for another opinion on the decision. A network provider is never an appropriate appealing party unless the beneficiary has appointed the provider, in writing, to represent him/her for the purpose of the appeal. The appeals process varies, depending on whether the denial of benefits involves medical necessity determination, factual determination, provider authorization, or a provider sanction. All initial and appeal 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.

Proper Appealing Parties

- The TRICARE beneficiary (including minors)
- The non-network participating (accepts assignment) provider of services
- A non-network participating (accepts assignment) provider appealing a preadmission/preprocedure denial (when services have not been rendered)
- A provider that has been denied approval as an authorized TRICARE provider or who has been terminated, excluded, suspended, or otherwise sanctioned
- A person who has been appointed in writing by the beneficiary to represent them in the appeal
- An attorney filing on behalf of a beneficiary
- A custodial parent or guardian of a beneficiary under 18 years of age

To avoid possible conflict of interest, an officer or employee of the U.S., such as an employee or member of the uniformed services (including an employee or staff member of a uniformed services legal office) subject to exceptions in Title 18, U.S. Code, Section 205, is not eligible to serve as a representative. An exception usually is made for an employee or uniformed services member who represents an immediate family member.

Medical Necessity Determinations

Medical necessity determinations are based solely on medical necessity—whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the beneficiary's condition. Generally, determinations relating to mental health benefits are considered medical necessity determinations. Below is the appeal process for non-expedited medical necessity determinations. There are expedited procedures for appealing decisions denying requests for pre-authorization of services and requests for continued inpatient stays. If an expedited appeal is available, the initial and appeal denial decisions will fully explain how to file an expedited appeal.

- Expedited appeal – must be received by the contractor within 3 calendar days of the date of the initial denial determination notification. Only the beneficiary, or the beneficiary's representative, may request an expedited appeal.
- Non-expedited appeal – must be received by the contractor within 90 days of the date of the 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. Below is the appeal process for factual determinations.

- Must be received by the contractor 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 TMA or TriWest may appeal those decisions and request a reconsideration. 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/her representative can appeal. If the sanctions are appealed, an independent hearing officer will conduct a hearing administered by the TMA 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. There must be a denial of an appeal due to untimely filing before an extension can be considered.

Levels of Appeals:

1. Reconsideration of the initial denial by the contractor
2. If the reconsideration results in the denial being upheld, then:

- Medical Necessity—appeal to National Quality Monitoring Contractor (NQMC)
- Factual—appeal to TRICARE Management Activity (TMA)

Non-appealable Issues

- Point-of-service determinations with the exception of whether services were related to an emergency and 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 since 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 for inpatient behavioral health

Waiver of Liability

A waiver of liability is used to appeal a denial of payment for health care services that required an approval prior to being rendered. Waiver-of-liability requests only apply to medical necessity issues after services have been rendered. Waiver-of-liability requests must be submitted in writing—either by the beneficiary or the non-network participating provider—to WPS in order to receive TRICARE reimbursement. A waiver of liability does **not** apply to factual benefit determinations (e.g., if TRICARE does not cover the service). A waiver of liability may be considered when neither the non-network participating provider nor the beneficiary could have reasonably known the service would be denied for medical necessity or appropriateness. A TRICARE beneficiary is not held liable for charges if the provider had prior knowledge that the services were excluded. A waiver of liability does **not** apply if the non-network participating provider or beneficiary had prior knowledge that the services were excludable. Waiver of liability 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 waiver-of-liability request is denied, then the the TRICARE beneficiary can be held financially liable if one of the following apply:

- Both the **non-network** participating provider and the beneficiary knew the services were excluded.
- The beneficiary did not notify the **non-network** participating provider of having TRICARE.
- The beneficiary knew the services were excluded but the **non-network** participating provider did not.

Waiver requests may be submitted to:

Wisconsin Physicians Service (WPS)
P. O. Box 77028
Madison, WI 53707-7028

Notes

Notes

Guidelines and procedural information for claims and billing

Claims Processing and Billing Information

Wisconsin Physicians Service (WPS) is TriWest's partner for claims processing. To receive claims processing information, please call 1-888-TRIWEST (1-888-874-9378). All claims are processed using current industry standards. Network providers are required to file claims electronically. All others are encouraged to file claims electronically but may file on paper.

To contact WPS about claims for dual-eligible beneficiaries (those eligible for both Medicare and TRICARE), see the explanation about filing claims for dual-eligible beneficiaries later in this section. All other inquiries should come through the following phone number or Web address:

Phone: 1-888-TRIWEST (1-888-874-9378)
Web site: www.triwest.com

TriWest will connect you to WPS via the Interactive Voice Response (IVR) system or by computer prompts on the Web site.

Filing Claims: Electronic Data Interface

The WPS staff is skilled in working with a variety of provider specialties, billing services, and software vendors. Choosing one of their electronic data interface (EDI) options assures providers of ample assistance throughout the claims filing process. The EDI edit systems are designed to minimize data entry errors before claims are passed to the WPS processing system.

Providers may choose an EDI software program from a vendor, clearinghouse, or billing service whose software already has been approved for TRICARE electronic claims submission. WPS's *EDI Connection* publication, available at www.wpsic.com/edi/pdf/tricareconnection.pdf, provides all the information providers need to make an informed vendor or clearinghouse selection.

EDI Software Option

Providers may choose an EDI software option provided by WPS. WPS claim entry software provides a stand-alone solution that creates a patient database and allows claim entry and claim transmission to WPS. WPS's print-file software converts print-image claim files from a practice management system into an electronic format for submission to WPS.

Internet Claim Submission

Providers may choose Internet claim submission. Professional and hospital providers can enter and submit TRICARE claims online over a secured Web site (www.triwest.com) and receive an immediate processing response. The claim entry screens have been designed to contain only the data that TRICARE requires for claims processing.

Fax-to-EDI Technology

Providers may choose Fax-to-EDI technology. Fax-to-EDI allows WPS to convert providers' faxed CMS-1500 claim forms into an electronic format for processing (837 transaction). The only equipment providers need is a fax machine.

WPS accepts direct submission of EDI claims 24 hours a day, seven days a week. EDI claims process quickly—meaning providers get reimbursed sooner. Providers experience lower administrative costs and reduce their postage costs and mailing time. Providers also receive immediate feedback with every step of the electronic claims processing cycle. Please contact one of WPS's EDI consultants for assistance in determining the best option for electronic claim submission.

You may contact WPS by phone, fax, mail, or e-mail for information about electronic claims.

Phone: 1-800-782-2680 or 1-608-221-7115
Fax: 1-608-223-3824
Mail: WPS Electronic Data Services
P.O. Box 8128
Madison, WI 53708-8128
E-mail: EDI@wpsic.com
Web site: www.wpsic.com/edi/edi_home.shtml

Filing Paper Claims

All paper claims should be sent to the following address:

West Region Claims
WPS
P.O. Box 77028
Madison, WI 53707-7028

Claims Processing Guidelines

Claims Processing Timelines

TriWest and WPS are committed to processing 99 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 Medicare's. Authorizations, referrals, and medical records **should not** be submitted with the claim. TriWest's referral and authorization system will link the claims to authorizations and referrals that have been entered by its staff. Please see the section entitled "Health Care Management Administration" for guidelines for referrals and authorizations.

Please allow 45 days to receive payment or a Provider Remittance Advice form before resubmitting claims. To verify processing of the claims prior to receiving the Provider Remittance Advice, TriWest encourages providers to register at the TriWest Provider Portal at www.triwest.com. Claims status information can also be obtained by using the IVR system at 1-888-TRIWEST (1-888-874-9378). TriWest will also respond to HIPAA-compliant Transaction 276/277.

Tracer Claims

Please avoid submitting tracer claims. TriWest prefers that providers either use its Web site or call on the status of previously submitted claims. All claims submitted are acknowledged either with a payment, a Provider Remittance Advice, or, in rare instances, are returned with a specific request for additional information. In no case is a claim received and not acknowledged.

Interest Charges

A physician or supplier cannot bill penalties or interest charges to a beneficiary if TRICARE fails to make timely payment on a bill. TRICARE pays the provider interest on clean claims (i.e., claims received with all necessary information and documentation) that are processed more than 30 days after receipt.

Billing with Unlisted Procedures

Some procedures may not be found in any level of Health Care Procedure Coding System (HCPSC). Typically, these are services that are rarely provided, or are unusual, variable, or unlisted procedures. When using an unlisted procedure code, the provider must supply appropriate documentation (e.g., operative report, lab report). If it is determined that an adequately descriptive code is contained in HCPCS, WPS will advise the provider of the correct code and process the claim. If after review the determination is that no existing code sufficiently describes the procedure, WPS will process the claim according to the documentation submitted.

Timely Filing

TriWest follows the TRICARE filing guidelines that require all claims to be submitted within one year of the end date of service. If an appropriate reason exists for accepting a claim after the timely filing limit, a letter detailing the reason and a copy of the claim must be submitted to:

TriWest Healthcare Alliance
Attn: Timely Filing Waiver Request
P.O. Box 42049
Phoenix, AZ 85080

Each case is reviewed by TriWest and given individual consideration.

Signature-on-File Requirements

When a TRICARE beneficiary has signed a Release of Information statement, providers should indicate "signature on file" in Block 12 of the CMS-1500. A new signature is required every year for professional claims submitted on a CMS-1500 and every admission for claims submitted on a UB-92.

If the beneficiary is under the age of 18, the parent or legal guardian should sign the claim. However, a beneficiary under the age of 18 may sign the claim form if the beneficiary is (or was) the spouse of an active duty service member 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. Please see the section entitled "Important Provider Information" for more information about the release of patient information.

The person signing should submit the following documentation to WPS and mail to the following correspondence address:

Wisconsin Physicians Service (WPS)
P.O. Box 77029
Madison, WI 53707-7029

- The beneficiary's name in the appropriate space on the claim form, followed by the word "by" and his/her own signature
- A statement giving his/her full name and address, relationship to the beneficiary, and the reason the beneficiary is unable to sign
- A statement that a legal guardian has not been appointed, if such is the case
- Documentation of appointment, if a legal guardian has been appointed, or if a power of attorney has been issued

If the beneficiary is deceased and the provider does not have a valid signature-on-file agreement, one of the following documents must be submitted:

- The legal representative of the estate must sign a claim form.
- Documentation must accompany the claim form to show the person signing is the legally appointed representative.
- If no legal representative has been appointed, the parent, the spouse, or the 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, or guardian, no next of kin, and no legal representative to sign the claim form for a deceased beneficiary, payment may be made to the provider in accordance with state law and TriWest 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

TRICARE randomly reviews claims to help ensure that signature-on-file requirements are being followed. Claims submitted for diagnostic tests, test interpretations, or other similar services do not require the beneficiary's signature. Providers submitting these claims must indicate "patient not present" on the claim form.

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 complete this acknowledgement at the time he/she is granted admitting privileges. The signed and dated acknowledgement remains in effect as long as the physician has admitting privileges at the institution. Any existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

Returning Incorrect Payments

If you receive an overpayment for a claim for TRICARE Standard, TRICARE Extra, or TRICARE Prime beneficiaries, TRICARE requests that this payment be returned to WPS. Duplicate payments for TRICARE For Life (TFL) claims should also be returned to WPS. Please include a copy of the Provider Remittance Advice and a cover letter explaining exactly why the money is being returned. If a Provider Remittance Advice is not included, please provide information about the beneficiary and the claim to help ensure that the refund is credited to the correct claim.

Return duplicate payments or overpayments to:

Wisconsin Physicians Service (WPS)
P.O. Box 77028
Madison, WI 53707-7028

Return TFL overpayments to:

Wisconsin Physicians Service (WPS)
Attn: TDEFIC
P.O. Box 77028
Madison, WI 53707-7028.

Special Processing Instructions

ECGs and Office Visit Billing

When an 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.

Lab and Radiology Billing

When submitting claims for laboratory or radiology services rendered in a hospital setting, inpatient or outpatient, the professional provider should use modifier "26" to indicate that he/she is 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, a professional provider should indicate whether or not they are billing for the global fee or only the professional component. The provider should use modifier "26" to indicate he/she is billing for the professional component only if sending the sample to a laboratory. The provider should also check "yes" in block 20 of the CMS-1500 or 837 transaction. This allows payment to the laboratory for the technical component. If the professional provider does not use a modifier and does not indicate "yes" in block 20 of the CMS-1500, he/she will be paid the global fee. Should the laboratory subsequently bill for the technical component, that claim will be denied.

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 block 20 of the CMS-1500 or 837 transaction to indicate if an outside laboratory was utilized. If the labs are drawn in a provider's office but read in an outside laboratory, TRICARE pays for the venipuncture.

ClaimCheck®

The TRICARE West Region contract uses a version of the McKesson HBOC ClaimCheck® product to review claims on a prepayment basis for unbundling. ClaimCheck is an automated product that contains specific auditing logic designed to evaluate professional billing for Current Procedural Terminology (CPT) coding appropriateness and to eliminate overpayment on professional and outpatient hospital claims.

TriWest updates ClaimCheck annually with new coding based on current industry standards.

ClaimCheck Edits

Providers 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:

- Procedure Unbundling
- Incidental Procedure
- Mutually Exclusive Procedure
- Assistant Surgeon Requirements
- Age Conflicts
- Gender Conflicts
- Alternate Code Replacements
- Cosmetic Procedures
- Unlisted Procedures
- Modifier Auditing
- Duplicate and Bilateral Procedures
- Preoperative (preop) and Postoperative (postop) Auditing Billed
- Billed Date(s) of Service

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

ClaimCheck Appeals

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 the provider submits additional documentation substantiating that unusual circumstances existed

Participating providers interested in a medical review should write to TriWest and provide additional documentation, if necessary. Following medical review, TriWest may override the ClaimCheck edit and allow additional amounts to be paid. These requests should be sent to:

TriWest Healthcare Alliance
ClaimCheck Appeal
P. O. Box 42049
Phoenix, AZ 85080

Providers are not permitted to bill TRICARE beneficiaries for amounts considered unbundled or incidental by ClaimCheck.

Outpatient Institutional Claims Processing

TriWest uses the Centers for Medicare and Medicaid Services (CMS) guidelines for reimbursement and claims processing. Hospitals, birthing centers, and ambulatory surgery centers reporting outpatient services on a UB-92 should indicate the HCPCS codes that best describe the services rendered in form locator 44. HCPCS Level I codes, Level II 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.

Reimbursement will be made according to the TRICARE allowable charge. 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. When using an unlisted procedure code, the provider must supply appropriate documentation (e.g., operative report, lab report). If it is determined that an adequately descriptive code is contained in HCPCS, WPS will advise the provider of the correct code and process the claim. If, after review, the determination is that no existing code sufficiently describes the procedure, WPS will process the claim according to the documentation submitted. The 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, durable medical equipment, orthotics, and prosthetics). These codes are also known as HCPCS codes.

All provider specialties and types of institutions, **except** the following, must report HCPCS codes on institutional claims. The following providers should report using the codes indicated:

Institution	Codes for Reporting
Pharmacies	National Drug Codes
Residential Treatment Centers	Revenue Codes
Skilled Nursing Centers	Revenue Codes
Christian Science Sanatoria	Revenue Codes
Dentists and Dental Services	American Dental Association Codes

Providers may obtain a matrix that indicates by revenue code, how reimbursement will be made on outpatient facility charges. The matrix is found in the provider portal at www.triwest.com.

Proper Treatment Room Billing

Revenue Code 76x

Knowing when to use revenue code 76x (treatment or observation room) to indicate use of a treatment room can be confusing and can lead to inappropriate billing.

Providers may indicate revenue code 76x for the actual use of a treatment room **in which a specific procedure has been performed or a treatment rendered**. Revenue code 76x may be appropriate for charges for minor procedures and in the following instances:

- An outpatient surgery procedure code (10040–69990)
- Interventional radiology services related to imaging, supervision, interpretation, and the related injection or introduction procedure
- Debridement (11040–11044) performed in an outpatient hospital department

Revenue code 76x should not be used when the claim is submitted with a type of bill 83x and ASC procedure codes. ASC facility services are reimbursed under the ASC revenue code reimbursement. It should also not be used when the HCPCS code is blank or is an evaluation and management code (e.g., 99201–99205, 99211–99215).

Revenue Code Series 51x

TriWest has determined that the TRICARE allowable charge reimbursement for covered medical services includes overhead and administrative costs. Therefore, revenue code series 51x is not reimbursed separately because it has been determined to be an overhead charge.

Charges submitted with revenue code series 51x are rebundled and denied with the explanation, “Reimbursement for this service was considered to be paid as part of the professional service. No additional reimbursement will be made. This charge may not be billed to the TRICARE beneficiary.” Due to the rebundling of charges, the allowable charge determination is based upon the single comprehensive code, which includes the entire procedure as well as administrative

costs. The following revenue codes are affected by this change:

Code	Description
510	Clinic, general class
511	Clinic, chronic pain
512	Clinic, dental
513	Clinic, psychiatric
514	Clinic, OB/GYN
515	Clinic, pediatric
516	Reserved
517	Clinic, family practice
518	Reserved
519	Clinic, other

If providers unbundle, ClaimCheck will indicate on the Provider Remittance Advice that unbundled services were included with the global charge and will not be reimbursed separately. Providers may not bill beneficiaries for the services disallowed by ClaimCheck. Additionally, they may not insist beneficiaries sign a waiver accepting liability for unbundled amounts. Providers who do so may be found to have committed fraud and may be subject to sanctions, including termination. **The only exception is for TFL claims.** The bundling edit for revenue code 510 does not apply to TFL claims.

Claims Over $100,000

TriWest's goal is to provide expedient claims processing. Processing claims with billed amounts exceeding $100,000 can be a complicated process. Providers can help expedite this process by providing all the necessary documents to WPS the first time a claim is submitted. Please note that TriWest reserves the right to request any or all of the following documents to annotate the amount paid in the other insurance field using Coordination of Benefits (COB) 837 transaction.

When submitting claims in excess of $100,000 please follow these guidelines:

- If the beneficiary has other health coverage that is primary to TRICARE, attach a copy of the Provider Remittance Advice from the primary payer showing the same billed charges as the claim you are submitting to TRICARE or submit COB 837 transaction.
- For diagnosis codes in the 800–999 range that could involve third-party liability, include a Third Party Liability (TPL) form. This may be submitted with the original billing but must be signed by the beneficiary or his/her representative. If the signature is missing from the TPL form, WPS will send it to the beneficiary for completion.
- Any and all documentation may be requested.
- Implants and devices with a billed charge of $50,000 or more may require an itemized invoice.

Other items that can expedite processing of claims in excess of $100,000 include a copy of the front and back of a beneficiary's military identification card and a copy of the beneficiary's birth or death certificate (if appropriate). This can help keep the Defense Enrollment Eligibility Reporting System (DEERS) updated with the most current information. You may also attach any other information you deem necessary or helpful.

Regional Claim Telephone Numbers

Providers who have a claim issue or question regarding a TRICARE patient who normally receives care in another TRICARE region can call the appropriate number listed below for assistance. Providers should submit claims to the region where the beneficiary resides and/or is enrolled in TRICARE Prime.

North Region
1-877-TRICARE (1-877-874-2273)

Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, North Carolina, Illinois, Indiana, Kentucky, Michigan, Missouri (St. Louis area), Ohio, Tennessee (Ft. Campbell area), West Virginia, and Wisconsin.

South Region
1-800-403-3950

Alabama, Florida, Georgia, Mississippi, South Carolina, Tennessee (excluding the Ft. Campbell area), Louisiana, Arkansas, Texas (excluding the El Paso area), Oklahoma, and Louisiana.

West Region
1-888-TRIWEST (1-888-874-9378)

Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (except the Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner including El Paso only), Utah, Washington, and Wyoming.

Claims for Dual-Eligible Beneficiaries (Eligible for Medicare and TRICARE)

WPS is the claims processor for all claims for beneficiaries who are eligible for both Medicare and TRICARE regardless of where the services are received. If you currently submit claims on your patient's behalf to Medicare, you will not need to submit a claim to WPS. WPS has signed agreements with each Medicare carrier allowing them to submit claims directly to WPS. This includes TRICARE beneficiaries under the age of 65 who did not have their claims previously submitted by Medicare. After the Medicare carrier completes processing of the claim, it will be submitted electronically to WPS TRICARE For Life. Beneficiaries will receive Provider Remittance Advice from WPS 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.

The following chart contains important contact information for you or your patients regarding dual-eligible claims:

Claims Submission	WPS TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890
Appeals	WPS TRICARE For Life Attn: Appeals P.O. Box 7490 Madison, WI 53707-7490
Program Integrity	WPS TRICARE For Life Attn: Program Integrity P.O. Box 7516 Madison, WI 53707-7516
Third Party Liability	WPS TRICARE For Life Attn: TPL P.O. Box 7897 Madison, WI 53707-7897
Refunds	WPS TRICARE For Life Attn: Refunds P.O. Box 7928 Madison, WI 53707-7928
Customer Service	WPS TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889
Toll-free	1-866-773-0404
Toll-free TDD Telephone	1-866-773-0405
Online	www.tricare4u.com

Claims for NATO Beneficiaries

Eligible family members of active duty members of the foreign North Atlantic Treaty Organization (NATO) nations who are stationed in, or passing through, the U.S. in connection with their official duties are eligible for outpatient services under TRICARE Extra or TRICARE Standard. These claims are identified by the word "NATO" written on the claim in the sponsor's SSN block. A copy of the ID card with the Foreign Identification Number (FIN) should be kept in the provider's file.

TRICARE and Other Health Insurance

TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, or other programs/plans as

identified by the TRICARE Management Activity (TMA). TRICARE beneficiaries who have other health insurance (OHI) are not required to obtain referrals or pre-authorizations for covered services, except for adjunctive dental care, organ transplants, and behavioral health care services. These services continue to require pre-authorization even when OHI coverage exists.

Providers 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 Reserve Component members. If a beneficiary's OHI status changes, make sure to update patient billing system records to avoid delays in claim payments.

Prime Point-of-Service Option

Point of service cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. However, there is a statutory requirement that the beneficiary needs to have pre-authorization for nonemergency inpatient behavioral health care, adjunctive dental, and organ transplantation, whether or not the beneficiary has OHI.

Computation of Payments

When OHI is involved, the provider of care may receive no more than the TRICARE allowable charge through payment by the OHI and TRICARE. Providers may not collect any amount from a beneficiary after payment of the claim unless TRICARE and the OHI combined have failed to pay the allowable charge (if network or accepting assignment) or the 115 percent of allowable charge (if not accepting assignment). In the case of a network provider, the contractually negotiated amount is the allowable charge.

TRICARE and Third-Party Liability Insurance

The Federal Medical Recovery Act allows the government to be reimbursed for its costs of treating a TRICARE beneficiary if the beneficiary was injured in an accident caused by someone else. TriWest is responsible for identifying and investigating all potential third party recovery claims. Claims submitted with diagnosis codes between 800 and 999 for professional services exceeding $500 and for all inpatient services, often indicate an accidental injury or illness and will be pended for development. Pending for development means that the claim will not be processed further until the beneficiary completes a DD Form 2527 (Statement of Personal Injury—Possible Third Party).

There are certain diagnosis codes that are exceptions to the development criteria:

910.2–910.7	911.2–911.7
912.2–912.7	913.2–913.7
914.2–914.7	915.2–915.7
916.2–916.7	917.2–917.7
918.0	918.2
919.2–919.7	

When the claim is received and appears to have possible third-party involvement as mentioned previously, the following will happen:

- The DD Form 2527 Statement of Personal Injury 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 within 800–999, the beneficiary may still be responsible to fill out the form. If not returned, the claim will be denied.

TRICARE and Workers' Compensation

TRICARE will not cost-share work-related illnesses or injuries that are covered under workers' compensation programs.

Avoiding Collection Activities

TRICARE providers should avoid sending a beneficiary's claim to a collection agency prior to:

- Submitting an administrative review request
- Requesting an adjustment on an Allowable Charge Review
- Or contacting TriWest at 1-888-TRIWEST (1-888-874-9378) or visiting www.triwest.com

Please wait at least 45 days after submitting a claim before contacting TriWest. If TriWest cannot resolve the problem, network providers should contact their local network representative and non-network providers should contact their TRICARE field representative at 1-888-TRIWEST (1-888-874-9378) for assistance.

Beneficiaries are responsible for their out-of-pocket expenses. A beneficiary should not be sent to collections before the non-network provider contacts his/her local network representative, unless the only amount outstanding is the beneficiary's deductible, cost-share, or copayment amount reflected on the Provider Remittance Advice.

TRICARE's Debt Collection Assistance Officer Program

Debt Collection Assistance Officers (DCAOs) are located at each TRICARE Regional Office and military treatment facility (MTF) to assist TRICARE beneficiaries in determining the validity of collection agent claims/negative credit reports received for debts incurred as a result of health care* under the TRICARE Program, and will take all measures necessary to resolve the issues presented. Beneficiaries must bring or submit documentation associated with a collection action or adverse credit rating to the DCAO. This includes debt collection letters, TRICARE EOBs, and health care bills from providers. The more information they can provide, the faster it will be to determine the cause of the problem. The DCAO will research their claim with the appropriate claims processor or other agency points of contact and provide them with a written resolution to their collection problem. The collection agency will be notified by the DCAO that action is being taken to resolve the issue.

DCAOs cannot provide beneficiaries with legal advice or fix their credit rating, but they can help them through the debt collection process by providing documentation for the collection or credit reporting agency in explaining the circumstances relating to the debt. The DCAO directory is available online at www.tricare.osd.mil/DCAODirectory.htm.

*"Health Care" includes medical and dental care under TRICARE.

Allowable Charge Review

An allowable charge review is a method for network and non-network providers who accept assignment (i.e., participate) to obtain a second opinion concerning the amount paid on a claim. To request this review, one of the following must have resulted in a discrepancy in the reimbursement amount:

- ClaimCheck bundling
- Multiple surgery resolution
- Number of units paid
- Level of reimbursement

To request an allowable charge review, network and non-network providers accepting assignment must submit a written request detailing the discrepancy, along with a copy of the Provider Remittance Advice to:

Wisconsin Physicians Service (WPS)
P. O. Box 77029
Madison, WI 53707-7029

For information about filing an appeal, see the section entitled "Health Care Management and Administration."

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Details about how TRICARE determines reimbursement for health care services

TRICARE Reimbursement Methodologies

TRICARE reimbursement methodologies include the following categories:

- CHAMPUS maximum allowable charge (CMAC)
- TRICARE allowable charge
- Anesthesia rates
- Ambulatory surgery grouper rates
- Diagnosis-related group (DRG) reimbursement
- Durable medical equipment regional carrier (DMERC) pricing
- Skilled nursing facility (SNF) pricing
- Home health pricing

Reimbursement rates and methodologies are subject to change per Department of Defense (DoD) guidelines. Visit www.tricare.osd.mil/manuals and see the TRICARE Reimbursement Manual for more information.

CHAMPUS Maximum Allowable Charge

The CMAC is the maximum amount TRICARE will cover for nationally established fees (i.e., fees for professional services). CMAC is the TRICARE allowable charge for covered services when appropriately applied to services priced under CMAC.

TRICARE Allowable Charge

The term "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 normally the lower of the actual billed charge and the allowable charge.

For example:

- If the allowable charge for a service is $90, and the billed charge is $50, TRICARE will pay $50 (actual billed charge).
- If the billed charge is $100, TRICARE will pay $90 (the allowable charge). In the case of inpatient hospital payments, the diagnosis-related group (DRG) is the TRICARE allowable charge regardless of the billed amount.

National Conversion Factors

TRICARE uses the conversion factors utilized by Medicare. The formulae are not identical to the Centers for Medicare and Medicaid Services (CMS), so the final calculation result will differ slightly from that calculated by Medicare. TRICARE physician payment levels under CMAC are equal to or higher than Medicare.

State Prevailing Rates

Prevailing rates are those 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 prevailing charge is developed for the state in which the service or procedure is provided. Unless a specific exception has been made, prevailing profiles are developed on:

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

Prevailing profiles are developed using a minimum of eight claims submitted for reimbursement to TRICARE. The prevailing rate determined for the service is an amount that equals 80 percent of the cumulative billed charge amounts.

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.

Anesthesia Rates

TRICARE reimbursement of anesthesia services is calculated using the number of time units, the Medicare relative value units, and the anesthesia conversion factor.

Ambulatory Surgery Grouper Rates

Ambulatory surgery facility charges fall into one of 11 TRICARE grouper rates. TRICARE payment rates established under this system apply only to the facility charges for ambulatory surgery.

Diagnosis-Related Group (DRG) Reimbursement

This is a reimbursement system for inpatient charges from facilities, which assigns payment levels to each DRG based on the average cost of treating all TRICARE beneficiaries in a given DRG. TRICARE payment rates, DRG weights, and wage indexes for calculating DRG-based payments are modeled on the Medicare prospective payment system (PPS). Cases are classified into the appropriate DRG by a grouper program. The grouper classifies each case into a DRG on the basis of:

- Principal and secondary diagnosis and procedure codes
- Sex
- Age
- Discharge status
- Presence or absence of complications and co-morbidities
- Birth weight for neonates

The grouper used for the TRICARE DRG-based payment system is the same as the Medicare grouper with some modifications.
Refer to the TRICARE Web site at www.tricare.osd.mil/provider for detailed information. Each DRG is assigned a relative weight by CMS based upon charge data for all Medicare inpatient hospital discharges. Each hospital has a customized base rate designed to adjust payment, commensurate with the hospital's cost of providing services. The type of hospital and the wage index for the geographic area determines the hospital base rate.

DRG relative weights and hospital base rates are adjusted yearly. Effective annually, from October 1 through September 30, updated rates reflect changes in health care resource consumption as well as economic factors. Changes to the DRG weights and wage indexes are published annually in the Federal Register. Payment is determined by multiplying the DRG relative weight by the hospital base rate. The DRG with the highest relative weight is the highest paying DRG. Regardless of actual costs, the hospital receives only the calculated payment. TRICARE does not currently recognize Medicare's "Critical Access Hospital" designation. Claims submitted for DRG reimbursements are not subject to ClaimCheck® logic.

DRG Calculations

Current DRG weights and ratios are available in the TRICARE Reimbursement Manual on the TRICARE Web site at www.tricare.osd.mil/manuals. This Web site also offers a DRG calculator.

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 should be sent directly to Wisconsin Physicians Service (WPS) 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 diagnoses 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, the provider should send related information to:

TriWest Healthcare Alliance
Attn: Higher-Weighted DRG Review
P. O. Box 42049
Phoenix, AZ 85080-2049

When submitting the adjustment request, the hospital must also provide the following information:

- 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-92
- 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

Note: TRICARE does not currently recognize Medicare's "critical access hospital" designation.

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:

- Psychiatric hospitals or units
- Hospitals within hospitals
- Rehabilitation hospitals or units
- Long-term hospitals
- Long-term-care hospitals
- Sole-community hospitals
- Pediatric hospitals
- Cancer hospitals
- Christian Science sanatoria
- Satellite facilities
- Hospitals outside the 50 United States, the District of Columbia, or Puerto Rico

Capital and Direct Medical Education Cost Reimbursement

Facilities may request capital and direct medical educational 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 WPS within 60 days after the 12th month following the close of the hospital's cost-reporting period. A 10 percent penalty per month will be assessed by WPS for requests received more than 60 days after the 12th month following the close of the cost-reporting period. This applies to teaching 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 information:

- Hospital name
- Hospital address
- Hospital TRICARE provider number
- Hospital Medicare provider number
- Time period covered (must correspond with the hospital's Medicare cost-reporting period)
- Total inpatient days provided to all beneficiaries in units subject to DRG-based payment
- Total TRICARE inpatient days, provided in "allowed" units, subject to DRG-based payment (excluding non-medically necessary inpatient days)

- Total inpatient days provided to active duty service members (ADSMs) in units subject to DRG-based payment
- Total allowable capital costs (must correspond with the applicable pages from the Medicare cost report)
- Total allowable direct medical education costs (must correspond with the applicable pages from the Medicare cost report)
- Total full-time equivalents for residents and interns
- Total inpatient beds as of the end of the cost-reporting period
- Title of official signing the report
- Reporting date

The submission must include a certification statement 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) must be reported to WPS within 30 days of the date the hospital is notified of the change. In addition, 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:

Wisconsin Physicians Service (WPS)
P. O. Box 77028
Madison, WI 53707-7028

Capital Cost Reimbursement Under DRG-based Payment System

On October 1, 1991, the CMS implemented its capital PPS. A 10-year transition period was established to change the payment methodology for Medicare inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology. Federal Fiscal Year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs under Medicare.

Now that Medicare's capital transition period is over, CMS no longer requires the completion of Worksheet B, Parts II and III (i.e., old and new capital schedules). TRICARE **will not** use the same methodology for calculating the recapture amount but will continue to reimburse capital as a pass-through cost in one specific year. Under TRICARE, the loss recapture should be calculated based on that portion of the hospital's business attributable to TRICARE in the year the loss occurred, which is standard accounting practice.

In order for hospitals subject to the TRICARE DRG-based payment system to continue to receive reimbursement of their capital costs for cost-reporting periods beginning on or after October 1, 2001, they will need to complete a separate cost report for TRICARE. To retain the information on Worksheet B, Parts II and III, hospitals will need to input an "N" on Worksheet S-2, line 36, which asks whether they receive fully prospective capital payments. If hospitals answer "N," the information will be retained, and the capital step down will be reflected on Worksheet D. On the Medicare cost reports, information flows from Worksheet B, Parts II and III, to Worksheet D, Parts I and II, which are the schedules needed for reimbursement of capital costs under TRICARE.

Since hospitals are required to file amended cost reports with TRICARE, they also will need a separate TRICARE capital costs report for the settled (audited) cost report. Hospitals will need to obtain a copy of their Medicare fiscal intermediary's final settled ECR (electronic cost report) file so that the answer on S-2, line 36, can be changed to "N," and the capital costs can be recalculated and reported to TRICARE.

Durable Medical Equipment Regional Carrier Pricing

Claims in the West Region are paid through the pricing for Durable Medical Equipment for Regional Contracts for Medicare (DMERC). The pricing is updated quarterly on the same schedule as Medicare's pricing.

Skilled Nursing Facility Pricing

Skilled nursing facilities (SNFs) are paid using the Medicare prospective payment system (PPS). SNF PPS rates cover all routine, ancillary, and capital costs of covered SNF services. SNF admissions require an authorization when TRICARE is the primary payer. Providers are asked to contact TriWest at 1-888-TRIWEST (1-888-874-9378) on the 20th day to allow

TriWest enough time to fully review the case and determine whether or not TRICARE will allow reimbursement after the 100th day. SNF admissions for children under age 10 and Critical Access Hospitals swing beds are exempt from SNF PPS and are reimbursed based on billed charges or negotiated rates. For additional details on SNF PPS please visit www.tricare.osd.mil/manuals.

Home Health Agency Pricing

TRICARE will reimburse Home Health Agencies (HHAs) a fixed case-mix and wage-adjusted, 60-day episode payment amount for professional home health services, along with routine and nonroutine medical supplies provided under the beneficiary's plan of care. Durable medical equipment (DME) orthotics, prosthetics, certain vaccines, injectable osteoporosis drugs, ambulance services operated by the HHA, and other drugs and biologicals administered by other than oral method will be allowed outside the bundled episode-of-care payment rates.

The variation in reimbursement among beneficiaries receiving home health care under this newly adopted prospective payment system will depend on the severity of the beneficiary's condition and expected resource consumption over a 60-day episode-of-care, with special reimbursement provisions for major intervening events, significant changes in condition, and low or high resource utilization. The resource consumption of these beneficiaries will be assessed using Outcome and Assessment Information Set (OASIS) selected data elements. The score values obtained from these selected data elements will be used to classify home health beneficiaries into one of 80 Home Health Resource Groups (HHRGs), based on their average expected resource costs relative to other home health care patients.

The HHRG classification determines the cost weight (i.e., the appropriate case mix weight adjustment factor that indicates the relative resources used and cost of treating different patients). The cost weight for a particular HHRG is then multiplied by a standard average prospective payment amount for a 60-day episode of home health care. The case-mix adjusted standard prospective payment amount is then adjusted to reflect the geographic variation in wages to come up with the final HHA payment amount. For additional details on HHA PPS, please visit www.tricare.osd.mil/manuals.

Other reimbursement methodologies include institutional outpatient reimbursement, mental health per diem rates, birthing center PPS, partial hospitalization PPS, residential treatment center PPS, and average wholesale price (AWP) for prescription drugs. See www.tricare.osd.mil/manuals for more information.

Updates to TRICARE Rates and Weights

TRICARE rates are subject to change on at least an annual basis. Annual rate changes are usually effective on the following dates:

February 1	CMAC Anesthesia Birthing Centers
October 1	DRG Residential Treatment Centers Mental Health Per Diem SNF PPS
November 1	Ambulatory Surgery Grouper
Quarterly (January, April, July, October)	DMERC Home Health PPS

The DoD decided to adjust the TRICARE reimbursement rates to mirror Medicare's levels. Updated rates and weights are accessible at www.tricare.osd.mil/provider.

Network providers may contact their local network representative for additional information. Non-network providers may contact their local TRICARE field representative for additional information.

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Additional resources to assist you in understanding TRICARE and doing your job

Provider Tools

Frequently Asked Questions

1. ***What is a Prime Service Area?***
   Prime service areas were formerly called catchment areas defined to be within a 40-mile radius (determined by ZIP code) of a military treatment facility (MTF). It now also includes areas containing a high concentration of TRICARE beneficiaries who are not within the catchment area of an MTF. TriWest has opted to establish seven such areas in Des Moines, IA; Springfield, MO; Minneapolis, MN; and Portland, Salem, Eugene, and Meford, OR. Eligible TRICARE Prime beneficiaries who reside within a prime service area may be required to receive certain services from a network provider. TriWest is required to offer TRICARE Prime in each prime service area.

2. ***Who determines TRICARE reimbursement rates?***
   Congress passed the Defense Appropriations Act establishing the uniform payment system for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), called the CHAMPUS maximum allowable charge (CMAC). When TRICARE was implemented, the TRICARE Enabling Statute [10 United States Code 1079 (h) (1)] gave the Secretary of Defense the authority to set the reimbursement rates for health care services provided to TRICARE beneficiaries. Those rates are set in accordance with the same reimbursement rules that apply to payments for similar services under Medicare [Title XVIII of the Social Security Act (42 USC 1395)]. Please see the section entitled "TRICARE Reimbursement Methodologies."

3. ***What types of procedures require prior authorization?***
   All inpatient hospital admissions and certain procedures require prior authorization. See the section entitled "Health Care Management and Administration."

4. ***How are maternity patients managed?***
   Military medicine focuses on family-centered care before, during, and after childbirth. MTFs in the West Region are committed to being responsive to maternity patients and flexible to their needs. They offer an extended military "family," knowledgeable about the separation aspects of military life. The family-centered care approach ensures that new military families get the best possible personalized, coordinated care during this special time. New mothers are encouraged to visit the Family Centered Care Web site at www.tricare.osd.mil/familycare when deciding where to obtain their maternity care.

5. ***Does TRICARE offer any programs for persons with disabilities?***
   Currently, the Program for Persons with Disabilities (PFPWD) provides financial assistance to reduce the effects of mental retardation or a serious physical disability. It is being replaced by the TRICARE Extended Care Health Option. See details about both programs in the section entitled "TRICARE Program Options."

6. ***Does TRICARE have any contracted laboratory services?***
   LabCorps Inc., is the preferred provider of laboratory services under TRICARE. Additional laboratories are available at www.triwest.com.

7. ***How does TRICARE define an emergency?***
   An emergency is defined as the sudden onset of a worsening condition that is threatening to life, limb, or eyesight. An emergency condition requires immediate attention either to treat the condition or relieve suffering from painful symptoms. Any delay in treatment or seeking appropriate care would risk permanent damage to the person's health. If a prudent layperson (someone of average knowledge of health and medicine)

would reasonably believe that a true emergency exists, then TRICARE will cover the emergency care.

8. If a patient is admitted following emergency care, does that admission require pre-authorization?

Yes, hospitals must notify TriWest at 1-888-TRIWEST (1-888-874-9378) within 24 hours of an emergency admission to obtain authorization. This 24-hour notification applies on weekends also. Except in cases of true emergencies, TRICARE Prime enrollees must also have approval from their primary care manager (PCM) or the admission may be covered under the TRICARE Prime point-of-service (POS) option.

9. Does TRICARE allow a 23-hour outpatient observation status?

Physicians may evaluate, stabilize, and treat patients when the need for a full admission is not clear, by using the 23-hour outpatient observation status. If after 23 hours, it becomes apparent that the patient must continue as an inpatient, authorization for the inpatient admission must be obtained.

When observation stays last 23-48 hours, medical documentation is required. A stay exceeding 48 hours is not authorized as an observation stay. It must be billed as an inpatient stay.

10. Do TRICARE Prime beneficiaries have coverage out of this region?

True emergencies are covered for TRICARE Prime beneficiaries traveling away from home, whether they are in or out of their TRICARE region. TriWest must be notified within 24 hours of an emergency hospital admission. Nonemergency care must be approved by the beneficiary's PCM and authorized by TriWest to ensure maximum TRICARE coverage. Routine care for TRICARE Prime enrollees may be covered under the POS option.

11. Where does my office file TRICARE claims?

Wisconsin Physicians Service (WPS) is TriWest's partner for claims processing. Refer to the section entitled "Claims Processing and Billing Information" for more information.

12. How do I order current TRICARE marketing and educational materials?

Network providers may contact their network representatives. Non-network providers may contact their TRICARE field representative. Providers may also visit the TriWest Provider Portal at www.triwest.com, which contains many educational materials.

Advance Directives

It is best to ask a patient early on in his/her care if he/she has a living will or other form of advance directive. Not only does this information get included in the patient's chart, but by raising the issue, the patient has an opportunity to clarify his/her wishes with the care providers and his/her family. However, advance directives take effect only in situations where a patient is unable to participate directly in medical decision making. Appeals to living wills and surrogate decision makers are ethically and legally inappropriate when individuals remain competent to guide their own care. The assessment of decisional incapacity is often difficult and may involve a psychiatric evaluation and, at times, a legal determination.

Some directives are written to apply only in particular clinical situations, such as when the patient has a "terminal" condition or an "incurable" illness. These ambiguous terms mean that directives must be interpreted by caregivers. More recent forms of instructive directives have attempted to overcome this ambiguity by addressing specific interventions (e.g., blood transfusions or CPR) that are to be prohibited in all clinical contexts.

What if a patient changes his/her mind?

As long as a patient remains competent to participate in medical decisions, both documents are revocable. Informed decisions by competent patients always supercede any written directive.

What if the family disagrees with a patient's living will?

If there is a disagreement about either the interpretation or the authority of a patient's living will, the medical team should meet with the family and clarify what is at issue. The team should explore the family's rationale for disagreeing with the living will. Do they have a different idea of what should be done? Do they have a different impression of what would be in the patient's best interests given his/her values and commitments? Or does the family disagree with the physician's interpretation of the living will?

These are complex and sensitive situations, and a careful dialogue can usually identify many other fears and concerns. However, if the family merely does not like what the patient has requested, they do not have much ethical power to sway the team. If the disagreement is based on new knowledge, substituted judgment, or recognition that the medical team has misinterpreted the living will, the family has much more say in the situation. If no agreement is reached, the hospital's Ethics Committee should be consulted.

How should I interpret a patient's advance directive?

Living wills generally are written in ambiguous terms and demand interpretation by providers. Terms like "extraordinary means" and "unnaturally prolonging my life" need to be placed in context of the patient's values in order to be meaningfully understood. More recent forms of instructive directives have attempted to overcome this ambiguity by addressing specific interventions (e.g., blood transfusions or CPR) to be withheld. The DPAHC or a close family member often can help the care team reach an understanding about what the patient would have wanted. Of course, physician-patient dialogue is the best guide for developing a personalized advance directive.

What are the limitations of living wills?

Living wills cannot cover all conceivable end-of-life decisions. There is too much variability in clinical decision making to make an all-encompassing living will possible. Persons who have written or are considering writing advance directives should be made aware of the fact that these documents are insufficient to ensure that all decisions regarding care at the end of life will be made in accordance with their written wishes. They should be strongly encouraged to communicate preferences and values to both their medical providers and family or surrogate decision makers.

Another potential limitation of advance directives is possible changes in the patient's preferences over time or circumstance. A living will may become inconsistent with the patient's revised views about quality of life or other outcomes. This is yet another reason to recommend that patients communicate with their physicians and family members about their end-of-life wishes.

Acronyms

AD	Active Duty
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AGR	Active Guard/Reserve
ASC	Ambulatory Surgery Center
BCAC	Beneficiary Counseling and Assistance Coordinators
BCF	Basic Core Formulary
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services (now called TRICARE)
CHAMPVA	Civilian Health and Medical Program of the Veterans Affairs (Veterans Affairs health care program for Medicare-eligible beneficiaries)
CHCBP	Continued Health Care Benefit Program
CMAC	CHAMPUS Maximum Allowable Charge
CMS	Centers for Medicare and Medicaid Services (formerly HCFA)
COB	Coordination of Benefits
COE	Centers of Excellence
CONUS	Continental United States
CPT	[Physician's] Current Procedural Terminology
CT	Computerized Tomography
DCAO	Debt Collections Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DHHS	Department of Health and Human Services
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DoD	Department of Defense
DOS	Date of Service
DRG	Diagnosis-Related Group
DSO	Defense Manpower Data Center (DMDC) Support Office
DTF	Dental Treatment Facility
DVA	Department of Veterans Affairs
EOB	Explanation of Benefits
EOI	Evidence of Insurability
ESRD	End-Stage Renal Disease
FAQ	Frequently Asked Questions
FDA	Food and Drug Administration
HBA	Health Benefits Advisor
HCF	Health Care Finder
HCFA	Health Care Financing Administration (now CMS)
HCPCS	Health Care Procedure Coding System
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMHS	Humana Military Healthcare Services
HMO	Health Maintenance Organization
ICD-9	9th International Congress in Diagnosis Codes
ID	Identification
IRR	Individual Ready Reserve
IV	Intravenous
MCSC	Managed Care Support Contractor
MHS	Military Health System
MMSO	Military Medical Support Office
MRI	Magnetic Resonance Imaging
MTF	Military Treatment Facility
NAS	Nonavailability Statement
NATO	North Atlantic Treaty Organization
NCI	National Cancer Institute
NCQI	National Committee for Quality Assurance
NDAA	National Defense Authorization Act
NG	National Guard
NOAA	National Oceanic and Atmospheric Administration
NQMC	National Quality Monitoring Contractor

OCONUS	Outside the Continental United States (Overseas)
ODTF	Overseas Dental Treatment Facility
OHI	Other Health Insurance
OTC	Over-the-Counter
P&T	Pharmacy and Therapeutics
PCM	Primary Care Manager
PCP	Primary Care Physician
PDTS	Pharmacy Data Transaction Service
PFP	Partners for Peace
PFPWD	Program for Persons with Disabilities
PGBA	Palmetto Government Benefits Administration
PHP	Partial Hospitalization Program
PHS	Public Health Service
POC	Point of Contact
POS	Point-of-Service
PPO	Preferred Provider Organization (TRICARE Extra)
QA	Quality Assurance
RC	Reserve Component
RDP	Remote Dental Program
RTC	Residential Treatment Center
SNF	Skilled Nursing Facility
SPOC	Service Point of Contact
SSN	Social Security Number
TAMP	Transitional Assistance Management Program
TDEFIC	TRICARE Dual-Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program
TFL	TRICARE For Life
THCDP	Transitional Health Care Demonstration Project
THCB	Transitional Health Care Benefit
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOL	TRICARE Online
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Members
TRDP	TRICARE Retiree Dental Program
TRO	TRICARE Regional Office
TRRx	TRICARE Retail Pharmacy Program
TSC	TRICARE Service Center
TSO	TRICARE Support Office
U.S.	United States
U.S.C.	United States Code
UCCI	United Concordia Companies, Inc.
USFHP	Uniformed Services Family Health Plan
USPHS	United States Public Health Service
VA	Department of Veterans Affairs, short for DVA
WIC	Women, Infants, and Children
WPS	Wisconsin Physicians Service

Glossary of Terms

Abuse

The improper or excessive use of program benefits, resources, or services by providers or beneficiaries. Abuse can be either intentional or unintentional and can occur when:

- Excessive or unnecessary services are used.
- Services are not appropriate for the beneficiary's condition.
- A beneficiary uses an expired or voided identification card.
- A more expensive treatment is rendered when a less expensive treatment would be as effective.
- A provider or beneficiary files false or incorrect claims.

and/or

- Billing or charging does not conform to TRICARE requirements.

Accepting Assignment

An accepting assignment is when a provider agrees to accept the TRICARE allowable charge(s), less any beneficiary cost-shares, copayments, or deductibles, as the full fee for care.

Allowable Charge, also TRICARE Allowable Charge

The term "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 normally the lowest of the actual billed charge or the allowable charge. For example, if the allowable charge for a service is $90, and the billed charge is $50, TRICARE will pay $50 (actual billed charge); if the billed charge is $100, TRICARE will pay $90 (the allowable charge). In the case of inpatient hospital payments, the diagnosis-related group (DRG) is the TRICARE allowable charge of the billed amount regardless. This is also known as participating on a claim. For network providers, the allowable charge is the negotiated rate.

Allowable Charge Review

An allowable charge review is a method by which a network provider may request a review of a claim he/she deems was paid at an inappropriate level.

Appeals Review

Method by which a non-network participating provider (i.e., one who has accepted assignment) may request a review of a claim he/she deems was paid at an inappropriate level.

Authorization

A review determination made by a licensed professional nurse or other health care professional for requested services, procedures, or admissions. Authorizations must be obtained prior to services being rendered or within 24 hours of an admission.

Authorized Provider

An authorized provider is a hospital or institutional provider, a physician or other individual professional provider, or other provider of services or supplies who meets the licensing and certification requirements of TRICARE in 32 CFR 199.6 and is practicing within the scope of that license. Any physician listed in 32 CFR 199.6 who holds a valid license to practice medicine in the state where he/she practices shall be an authorized provider. Providers not specifically listed in 32 CFR 199.6 are not considered authorized providers unless they are included in a TRICARE demonstration project.

Balance Billing

A term used to describe when a provider bills a beneficiary for the rest of the charges (the "balance" of the charges not to exceed 15 percent of the allowable charge for non-network providers, or not to exceed the negotiated rate for network providers), after TRICARE (and other health insurance) has paid everything it's going to pay. Network providers are prohibited from balance billing.

Beneficiary
A person who is eligible for TRICARE benefits.

Beneficiary Counseling and Assistance Coordinators (BCACs)
Persons at military treatment facilities (MTFs) and TRICARE service centers who are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining medical care through TRICARE. BCACs were previously known as Health Benefits Advisors or HBAs.

BRAC Site
A military base that has been closed or targeted for closure by the Government's Base Realignment and Closure Commission (BRAC).

Care Coordination
An approach to care management using proactive methods to optimize health outcomes and reduce risks of future complications over a short-term (two to six weeks) single episode of care. Prospective and concurrent reviews are used to identify current and future beneficiary needs.

Case Management
A collaborative process normally associated with multiple episodes of health care intervention that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet a beneficiary's complex health needs. This is accomplished through communication and available resources that promote quality, cost-effective outcomes.

Catastrophic Cap
The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given fiscal year (October 1–September 30). The catastrophic cap for active duty families is $1,000, and the catastrophic cap for all other TRICARE eligible families is $3,000.

Centers for Medicare and Medicaid Services (CMS)
The Federal agency that oversees all aspects of health care claims filing for Medicare (formerly known as the Health Care Financing Administration or HCFA).

Certified Provider
A hospital or institutional provider, physician, or other individual professional provider of services or supplies specifically authorized by 32 CFR 199.6. Certified providers have been verified by TRICARE Management Activity (TMA) or TriWest to meet the standards of 32 CFR 199.6 and have been approved to provide services to TRICARE beneficiaries and receive government payment for services rendered to TRICARE beneficiaries.

CHAMPUS Maximum Allowable Charge
The maximum amount TRICARE will cover for nationally established fees (i.e. fees 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 coverage for active duty family members (ADFMs), retirees and their family members. TRICARE was organized as a separate office under the Assistant Secretary of Defense and replaced CHAMPUS in 1994. Benefits covered under CHAMPUS are now covered under TRICARE Standard.

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)
A federal health benefits program for family members of 100-percent totally and permanently disabled veterans. CHAMPVA is administered by the Department of Veterans Affairs and is not associated with the TRICARE program. For questions regarding CHAMPVA, call 1-800-733-8387 or 1-303-331-7599.

Circumvention
A term used to describe inappropriate medical practices or actions that result in unnecessary multiple admissions of an individual.

ClaimCheck®
A customized, automated claims auditing system that verifies the clinical accuracy of professional claims.

CMS-1500
Formerly known as the HCFA-1500, the CMS has changed the name of its claim form to CMS-1500. Providers may continue to use HCFA-1500 forms they already have in stock, but will be required to order CMS-1500 forms when their supplies are exhausted. The form itself has not changed.

Concurrent Review
A review performed during the course of a beneficiary's inpatient admission with the purpose of validating the appropriateness of the admission, level of care, medical necessity, and quality of care, as well as the information provided during earlier reviews. Additional functions performed include screening for case management and identification of discharge planning needs. The review may be conducted by telephone or on-site. Concurrent reviews are generally performed when TRICARE is the primary insurer. Concurrent reviews that indicate criteria are not met are referred for medical director review.

Copayment
The fixed amount a TRICARE Prime enrollee will pay for care in the civilian provider network. Active duty family members (ADFMs) are not required to make copayments.

Cost-Share
The percentage of the allowable charges a beneficiary will pay under TRICARE Extra and TRICARE Standard. The cost-share depends on the sponsor's status—active duty or retired.

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.

Current Procedural Terminology (CPT)
A systematic listing and coding of procedures and services performed by physicians. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physician is accurately identified.

Deductible
The annual amount a TRICARE Extra or TRICARE Standard beneficiary must pay for covered outpatient benefits before TRICARE begins to share costs. TRICARE Prime beneficiaries do not have an annual deductible, unless they are utilizing their point-of-service (POS) option.

Defense Enrollment Eligibility Reporting System (DEERS)
A system operated by the Department of Defense and used by TRICARE contractors to determine and confirm the eligibility of beneficiaries. Beneficiaries are responsible for maintaining the accuracy of their DEERS records and updating the system as necessary.

Diagnosis-Related Group (DRG)
A reimbursement methodology used for inpatient care in some hospitals.

Discharge Planning
A process that assesses requirements and the coordination of care for a beneficiary's timely discharge from an acute inpatient setting to a post-care environment without need for additional military treatment facility (MTF) or civilian provider assistance.

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.

Enrollee
A TRICARE beneficiary who has elected to enroll in TRICARE Prime, TRICARE Prime Remote (TPR), or TRICARE Prime Remote for Active Duty Family Members (TPRADFM).

Explanation of Benefits (EOB)
A statement sent to beneficiaries showing that claims were processed and the amount paid to providers. If denied, an explanation of denial is provided.

Express Scripts, Inc.
The contractor responsible for providing a national network of civilian retail pharmacies for the TRICARE Retail Pharmacy Program, as well as for administering the national TRICARE Mail Order Pharmacy (TMOP) program (www.express-scripts.com).

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 (SSN) and most often starts with six or nine. TRICARE will not issue an authorization for treatment or services to NATO beneficiaries without a valid FIN.

Fraud
An instance in which deliberate deceit is used by a provider to obtain payment for services not actually delivered or received, or by a beneficiary to claim program eligibility.

Health Care Financing Administration (HCFA)
The former name of the Centers for Medicare and Medicaid Services or CMS.

Health Care Finder (HCF)
Representatives who help locate TRICARE providers and applicable community, state, and federal health care resources for beneficiaries who require benefits and services beyond TRICARE.

Health Care Procedural Coding System (HCPCS)
A set of codes used by Medicare that describes services and procedures. HCPCS includes Current Procedural Terminology (CPT) codes for services not included in the normal CPT code list, such as durable medical equipment and ambulance service. While HCPCS is nationally defined, there is a provision for local use of certain codes.

HIPAA
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was introduced to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to simplify the administration of health insurance; and for other purposes.

Health Management Strategic International (HMSI)
A company that has developed behavioral health review criteria for medical necessity reviews.

Initial Denial
Made only after second-level review if the care or treatment is not found to be medically necessary, reasonable, or at the appropriate level. The non-network, participating provider or beneficiary may request a reconsideration of the initial denial. See “Second-level Review” for clarification.

Managed Care
A concept under which an organization delivers health care to enrolled members and controls costs by closely supervising and reviewing the delivery of health care.

Managed Care Support Contractor (MCSC)
The Military Health System's (MHS') civilian health care partners who administer TRICARE in each of the TRICARE regions.

Medical Emergency
A medical condition manifesting itself by "acute symptoms of sufficient severity—including severe pain—such that a prudent layperson could reasonably expect the absence of medical attention to result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." In the case of a pregnant woman, the danger should be considered to adversely affect the health of the woman or her unborn child. A provider qualified to furnish emergency services and those needed to evaluate or stabilize an emergency medical condition must furnish inpatient or outpatient emergency services.

Medically Necessary
Appropriate and necessary treatment of the beneficiary's illness or injury according to accepted standards of medical practice and TRICARE policy. Medical necessity must be documented in clinical notes.

Military Treatment Facility (MTF)
A medical facility operated by the military that may provide inpatient and/or ambulatory care to eligible TRICARE beneficiaries. MTF capabilities vary from limited acute care clinics to teaching and tertiary care medical centers.

Network Provider
A network provider is one who serves TRICARE beneficiaries by agreement with the MCSC as a member of the TRICARE Prime network or any other preferred provider network or by any other contractual agreement with the MCSC. A network provider accepts the negotiated rate as payment in full for services rendered.

Nonavailability Statement (NAS)
A certification from an MTF that a specific health care service or procedure cannot be provided.

Non-network Provider
A non-network provider is one who has no contractual relationship with the MCSC to provide care to TRICARE beneficiaries, but is certified to provide care to TRICARE beneficiaries. A non-network provider must be authorized. There are two types of non-network providers—"participating" and "nonparticipating."

Nonparticipating Provider
A nonparticipating provider is a certified hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to TRICARE beneficiaries, but who has not signed a contract and does not agree to "accept assignment."

North Atlantic Treaty Organization (NATO) Member
A member of a foreign NATO nation's armed forces who is on active duty and who, in connection with official duties, is stationed in or passing through the U.S. The foreign NATO nations are Belgium, Canada, Czech Republic, Denmark, France, Federal Republic of Germany, Greece, Hungary, Iceland, Italy, Luxembourg, the Netherlands, Norway, Poland, Portugal, Spain, Turkey, and the United Kingdom.

Other Health Insurance (OHI)
Any non-TRICARE health insurance that is not considered a supplement. 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, TRICARE supplements, the Indian Health Service, or other programs or plans as identified by TRICARE Management Activity (TMA).

Participating Provider
Providers who participate in TRICARE, also called "accepting assignment," and who agree to accept the TRICARE-determined allowable cost or charge as the total charge for services—also known as the TRICARE allowable charge as the full fee for care. In the case of network providers, the negotiated

rate is considered the full fee for care. Non-network, individual providers may participate on a case-by-case basis. Providers may seek applicable copayments, cost-shares, and deductibles from the beneficiary. Hospitals that participate in Medicare must, by law, also participate in TRICARE for inpatient care. For outpatient care, they may or may not participate.

Peer Review Organization (PRO)
An organization charged with reviewing provider quality and medical necessity.

Per Diem
A reimbursement methodology based on a per-day rate that is currently used for behavioral health institutions and partial hospitalization programs.

Point of Service (POS)
An option that allows a TRICARE Prime beneficiary to obtain medically necessary services—inside or outside the network—from someone other than his/her primary care manager, without first obtaining a referral or authorization. Utilizing the POS option results in a deductible and greater out-of-pocket expenses for the beneficiary.

Pre-Authorization
See the definition for Prior Authorization.

Preferred Provider Organization (PPO)
A network of health care providers who provide services to patients at discounted rates or cost-shares. TRICARE Extra is considered to be a Preferred Provider Organization option.

Primary Care Manager (PCM)
A TRICARE civilian network provider or military treatment facility provider who provides primary care services to TRICARE beneficiaries*. A PCM is either selected by the beneficiary or assigned by a military treatment facility commander or his/her designated appointee. To the extent consistent with governing state rules and regulations, PCMs can include internists, family practitioners, pediatricians, general practitioners, obstetricians, gynecologists, physician assistants, nurse practitioners, or certified nurse midwives. (*TRICARE Prime Remote beneficiaries may choose a TRICARE certified provider if a network provider is not available.)

Prime Service Area
Formerly called catchment area and defined to be within a 40-mile radius (determined by ZIP code) of a military treatment facility (MTF). It now also includes areas containing a high concentration of TRICARE beneficiaries and who are not within the catchment area of an MTF. The MCSC is required to offer TRICARE Prime in each prime service area.

Prior Authorization
A review determination made by a licensed professional nurse or paraprofessional for requested services, procedures, or admissions. Prior authorizations must be obtained prior to services being rendered or within 24 hours of an admission.

Prospective Review
A screening process used to evaluate the medical necessity and appropriateness of a treatment or service proposed. The review is prospective (before the care or service is performed) and criteria-based. A registered nurse, physician assistant, or physician performs reviews. A first-level (i.e., prospective) review may result in an authorization of services or in a referral to second-level review. A prospective review never results in a denial of care or treatment.

Reconsideration or Appeal
A formal written request by an appropriate appealing party or an appointed representative to resolve a disputed statement of fact.

Referral
The process by which a PCM refers a TRICARE Prime beneficiary to another professional or ancillary provider for specialized medical services, prior to those services being rendered. The MCSC must approve referrals.

Region
A geographic area determined by the Federal Government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

Remittance Advice
A statement sent to providers showing that claims were processed and the amount for which the beneficiary is responsible. If denied, an explanation of denial is provided.

Reserve Component
The Reserve Component includes the Army National Guard, the Army Reserve, the Naval Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the U.S. Coast Guard Reserve.

Resource Sharing Agreement (RSA)
There are two types of RSAs. External RSAs are arrangements that allow military providers to render medical services to TRICARE beneficiaries in civilian network medical facilities. Internal RSAs are arrangements that allow civilian providers into the MTF system to render medical services to TRICARE beneficiaries.

Retrospective Review
A review of a beneficiary's medical record that occurs after the services have been rendered.

Second-level Review
Cases that do not meet the prospective review screening criteria are referred for physician review at the second level.

Split Enrollment
Refers to multiple family members enrolled in TRICARE Prime under different TRICARE regions or MCSCs.

Sponsor
The active duty service member or retiree through whom family members are eligible for TRICARE.

Supplemental Insurance
Health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance (OHI) 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.

Tax Identification Number
A tax identification number is a number assigned by the State in which a business or entity is operated that identifies it for filing and paying taxes related to the business or entity.

Treatment Plan
A treatment plan is a multidisciplinary care plan for each beneficiary in active case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, military resources, all funding options, treatment goals, and assessment of the beneficiary environment. The plan is updated monthly and modified when appropriate. These plans are developed in collaboration with the attending physician and beneficiary or guardian.

TriWest Hubs
Located throughout the TRICARE West Region and staffed with clinical personnel that work with providers by reviewing and responding to all referral or authorization requests. See the section entitled, "Welcome to TRICARE and the West Region," for more information about TriWest Hubs.

Sample Identification Cards

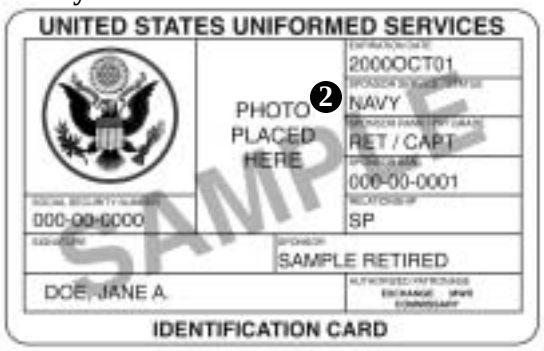
Uniformed Services Identification Cards

The uniformed services identification (ID) card is credit card sized and incorporates a digital photograph 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:

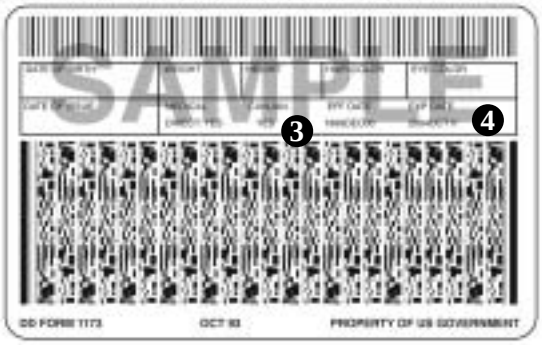
- Active duty service members—green
- Active duty family members—tan
- Members of the Reserve Component and their eligible family members—red
- Retirees—blue
- Retiree family members—tan

Sponsor Card

Family Member Card



Back of Cards



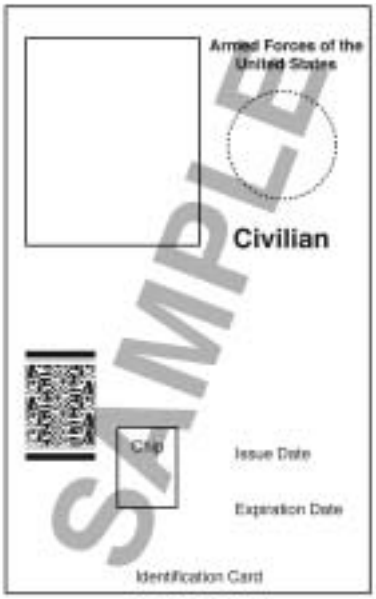
1. Rank and Pay Grade: Indicates rank and pay grade of the sponsor.
2. Sponsor Status: Indicates the sponsor's status (active duty or retired—should say "INDEF" for retirees).
3. Eligibility: Check the back of the ID card to verify eligibility for TRICARE. The center section should say, "YES" under the box entitled, "CIVILIAN." If a beneficiary using TRICARE For Life (TFL) has an ID card that says "NO" in this block, they are still eligible to use TFL if they are enrolled in Medicare Part B.
4. Expiration Date: Check the expiration date on the ID card in the box entitled, "EXP DATE." If expired, the beneficiary will need to update their information in the Defense Enrollment Eligibility Reporting System (DEERS) and get a new card.

Beneficiaries under the age of 10 are not routinely issued ID cards, so the parent's ID card may serve as proof of eligibility.

The Department of Defense (DoD), in conjunction with the seven uniformed services, began issuing this style of identification (ID) card in 1994. The Common Access Card (CAC) is replacing this style and is being phased in over the next few years. Please honor these cards. They are valid uniformed services ID cards.

Common Access Card

The Common Access Card (CAC) is replacing the current uniformed services ID card, described above. The following is an example of the new CAC.



Copying ID Cards

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

Although some TRICARE beneficiaries may believe that its illegal to copy ID cards, it is in fact, legal to copy them for authorized purposes†. The legitimate cardholder may allow his/her military or uniformed services ID card to be photocopied to facilitate medical care eligibility determination and documentation, check cashing, or the administration or other military-related benefits. Per TMA instruction, it is both allowable and advisable for providers to copy the beneficiary's ID card for proof of eligibility and for the purpose of rendering needed services. TMA recommends that providers copy both sides of the ID cards and retain copies for future reference.

†Title, 18 USC, 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/her to obtain benefits, privileges, or access to which he/she is not entitled.

TRICARE Prime Enrollment Card

Beneficiaries enrolled in TRICARE Prime, TRICARE Prime Remote (TPR), and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) receive TRICARE Prime enrollment cards. Network providers may require beneficiaries to show the card at the time of service. These cards are not required to obtain care, but do contain important information for the beneficiary. Only the uniformed services ID card or new CAC card may be used to verify eligibility for care.

Sample Forms

Samples of important TRICARE forms are illustrated on the following pages. To download these forms, visit www.triwest.com.

- **Health Insurance Claim Form**
- **Uniform Bill Form (UB-92)**
- **Statement of Personal Injury/Third Party Liability Form**
- **Waiver of Limitation Form**
- **Waiver of Non-Covered Services Form**
- **TRICARE Other Health Insurance Questionnaire Form**
- **An Important letter from TRICARE**

SAMPLE—Do not use.

Current form can be found at www.triwest.com.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA 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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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 CHAMPUS 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, including employment status, 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 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS 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, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). 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 subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, 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 1086; 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 that 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. 09-70-0501, 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 OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS 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 CHAMPUS/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 of care, on matters 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 CHAMPUS.

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 0938-0008. 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, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Health Insurance Claim Form, (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 "CHAMPUS."
BOX 1A	Sponsor's Social Security 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	Marital and employment status of patient

Note: *Box 11D should be completed prior to determining the need for completing boxes 9A through 9D. If Box 11D is checked "yes", Boxes 9A and 9D must be completed. In addition, 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	Other insured's date of birth and sex (Not required, but preferred)
BOX 9C	Other insured's employer name or name of school
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 where it occurred.)

Note: *Box 11 through Box 11C questions pertain to the sponsor.*

BOX 11	Indicate policy group or Federal Employees Compensation Act (FECA) number (if applicable).
BOX 11A	Sponsor's date of birth and sex, if different than Box 3
BOX 11B	Sponsor's branch of service
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 the 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 or injury/ Date of pregnancy (Required for injury or pregnancy)
BOX 15	First date (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 number of referring physician (Not required, but preferred)
BOX 18	Admit and discharge date of hospitalization
BOX 19	Referral number
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 one, and up to four, specific diagnosis codes.
BOX 23	Pre-authorization number
BOX 24A	Date of service
BOX 24B	Place of service
BOX 24C	Type of service

BOX 24D	CPT/HCPC procedure code with modifier, if applicable
BOX 24E	Diagnosis code or related item number
BOX 24F	Charges for listed service
BOX 24G	Days or units for each line item
BOX 24J	Coordination of Benefits (COB)
BOX 24K	State license number of attending physician. If the service is performed in a clinic, provide the name and title of the person who administered care.
BOX 25	Physician's/Supplier's Tax Identification 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 30	Amount due after other payments are applied (Required if OHI)
BOX 31	Authorized signature (If not entered in Box 24K, state license number)
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 this address.
BOX 33	Physician's/Supplier's billing name, address, ZIP code and phone number

CMS-1500 Place of Service Codes

11	Office
12	Home
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room - hospital
24	Ambulatory surgical center
25	Birthing center
26	Military treatment facility (MTF)
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance, land
42	Ambulance, air or water
51	Inpatient psychiatric facility
52	Psychiatric facility, partial hospitalization
53	Community mental health center
54	Intermediate care center/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory
99	Other unlisted facility

Type of Service Codes

1	Medical care
2	Surgery
3	Consultation
4	Diagnostic x-ray
5	Diagnostic laboratory
6	Radiation therapy
7	Anesthesia
8	Assistant at surgery
9	Other medical service
A	Durable Medical Equipment (DME) rental/purchase
B	Drugs
C	Ambulatory surgery
D	Hospice
E	Second opinion on elective surgery
F	Maternity
G	Dental
H	Mental health care
I	Ambulance
J	Program for Persons with Disabilities (PFPWD)

Uniform Bill Form (UB-92), page 1

SAMPLE—Do not use.

Current form can be found at www.triwest.com.

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7 COV D.

8 N-C D.

9 C-I D.

10 L-R D.

11

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE

15 SEX

16 MS

ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC

21 D HR

22 STAT

23 MEDICAL RECORD NO.

CONDITION CODES 24 25 26 27 28 29 30

31

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE CODE DATE

36 OCCURRENCE SPAN CODE FROM THROUGH

37 A B C

38

39 VALUE CODES CODE AMOUNT

40 VALUE CODES CODE AMOUNT

41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
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23								

50 PAYER

51 PROVIDER NO.

52 REL INFO

53 ASG BEN

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56

57

DUE FROM PATIENT ▶

58 INSURED'S NAME

59 P. REL

60 CERT. - SSN - HIC. - ID NO.

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 ESC

65 EMPLOYER NAME

66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.

68 CODE

69 CODE

70 CODE

71 CODE

72 CODE

73 CODE

74 CODE

75 CODE

76 ADM. DIAG. CD.

77 E-CODE

78

79 P.C.

80 PRINCIPAL PROCEDURE CODE DATE

81 OTHER PROCEDURE CODE DATE A

OTHER PROCEDURE CODE DATE B

OTHER PROCEDURE CODE DATE C

OTHER PROCEDURE CODE DATE D

OTHER PROCEDURE CODE DATE E

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID A

OTHER PHYS. ID B

84 REMARKS

85 PROVIDER REPRESENTATIVE X

86 DATE

UB-92 HCFA-1450

OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or 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 particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

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 Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing 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 their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   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.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance 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 coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS 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 but excluding contract surgeons or other personnel employed by the Uniformed Services through 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 the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, 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. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Uniform Bill Form (UB-92) (instructions)

The following listing of UB-92 form locators is a summary of the form locator information.

FL 1	Provider name, address and telephone number required. The minimum entry is the provider's name, address, city, state, and ZIP code. Telephone and/or fax numbers are also desired.
FL 2	Not required
FL 3	Patient Control Number
FL 4	Type of Bill (Three-digit alphanumeric number)
FL 5	Federal Tax Identification 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 8	Not Required
FL 9	Not Required
FL 10	Not Required
FL 11	Not Required
FL 12	Patient's Name (Surname first, first name, and middle initial, if any)
FL 13	Patient's full address to include: state, city, street name and number, Post Office Box number, ZIP code and /or RFD
FL 14	Patient's Birthdate (MM-DD-YYYY). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.
FL 15	Patient Sex. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.
FL 16	Patient's Marital Status
FL 17	Admission Date
FL 18	Admission Hour
FL 19	Type of Admission. This code indicates priority of the admission.
FL 20	Source of Admission. This code indicates the source of admission or outpatient registration.
FL 21	Discharge Hour
FL 22	Patient Status. This code indicates the patient's status as of the "Through" date of the billing period (FL 6).
FL 23	Medical Record Number
FLs 24-30	Condition Codes
FL 31	Not Required
FLs 32-35	Occurrence Codes and Dates
FL 36	Occurrence Span Code and Dates
FL 37	Not Required
FL 38	Not Required
FL 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.
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, etc.). 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
FL 50a,b,c	Payer Identification. Enter the primary payer on line A.
FL 51a,b,c	Provider Number
FL 52a,b,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.
FL 53a,b,c	Assignment of Benefits Certification Indicator
FL 54a,b,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 (fourth/last) line of this column.

FL 55a,b,c Not Required

FL 56 Not Required

FL 57 Not Required

FL 58a,b,c Insured's Name

FL 59a,b,c Patient's Relationship to Insured

FL 60a,b,c Certificate/Social Security Number/Health Insurance Claim/Identification Number

FL 61a,b,c Group Name. Indicate the name of the insurance group or plan.

FL 62a,b,c Insurance Group Number

FL 63 Treatment Authorization 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.

FL 64 Employment Status Code. Enter the code which defines the employment status of the individual identified on line FL 58, if available.

FL 65 Employer Name. Name of the employer that provides health care coverage for the individual identified on FL 58.

FL 66 Employer Location. Enter the specific location (city, plant, etc.) of the employer of the individual identified on FL 58.

FL 67 Principal Diagnosis Code. HCFA only accepts ICD-9-CM diagnostic and procedural codes which use definitions contained in Department of Health and Human Services (DHHS) Publication Number (PHS) 89-1260 or HCFA approved errata supplements to this publication. Diagnosis codes must be full ICD-9-CM diagnosis codes, including all five digits where applicable.

FL 68-75 Other Diagnosis Codes

FL 76 Admitting Diagnosis. For inpatient hospital claims subject to Peer Review Organization (PRO) review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL 77 Not Required

FL 78 Not Required

FL 79 Procedure Coding Method

FL 80 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.

FL 81 Other Procedure Codes and Dates. The full ICD-9-CM, Volume 3, Procedure Codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL 80). The date of each procedure is shown in the date portion of Item 81, as applicable (MM-DD-YY).

FL 82 Attending/Referring Physician ID. Providers must enter the Unique Physician Identification Number (UPIN) and name of the attending/referring physician on inpatient bills or the physician that requested outpatient services.

FL 83 Other Physician ID

FL 84 Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements.

FL 85 Provider Representative Signature

FL 86 Date. This is the date the provider's representative signed the UB-92 form.

Condition Codes

02 Condition is employment related

03 Patient covered by insurance not reflected here

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 Semi-private room not available
39 Private room medically necessary
46 Non-availability statement on file
48 Psychiatric residential treatment centers for children and adolescents
55 Skilled Nursing Facility (SNF) bed not available
56 Medical appropriateness
60 Day outlier
61 Cost outlier
67 Beneficiary elects not to use life time reserve days
0A TRICARE External Partnership Program
A2 Physically Handicapped Children's Program
A7 Induced abortion—danger to life
A8 Induced abortion—victim rape/incest
C1 Approved as billed
C2 Automatic approval as billed based on focused review
C3 Partial approval
C4 Admission/services denied
C5 Postpayment review applicable
C6 Admission pre-authorization
C7 Extended authorization

Occurrence Span Codes

01 Auto accident
02 No fault insurance involved—including auto accident/other
03 Accident/tort liability
04 Accident/employment related
05 Other accident
06 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 Skilled Nursing Facility bed became available
27 Date of hospice certification or re-certification
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 End Stage Renal Disease (ESRD) beneficiaries covered by Employer Group Health Plan (EGHP)

Value Codes and Amounts

01 Most common semi-private rate
02 Hospital has no semi-private 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

SAMPLE—Do not use.

Current form can be found at www.triwest.com.

STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY

CHAMPUS

Form Approved
OMS No. 0720-0003
Expires Jun 30, 2002

IF A PREADDRESSED ENVELOPE IS NOT ENCLOSED WITH THIS FORM, PLEASE RETURN YOUR COMPLETED FORM TO EITHER OF THESE LOCATIONS:

(1) THE CHAMPUS CLAIMS PROCESSOR WHO SENT YOU THE FORM; OR

(2) THE CHAMPUS CLAIMS PROCESSOR FOR THE STATE/COUNTRY IN WHICH YOU RECEIVED THE MEDICAL CARE (the Health Benefits Advisor at your nearest military installation can provide you with this address).

The public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0003), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22207-4307. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.
PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THIS ADDRESS.

PRIVACY ACT STATEMENT

AUTHORITY: 42 U.S.C. 2651-2653; 10 U.S.C. 1079, 1085, 1086 and 1092; E.O. 9397; 38 U.S.C. 613.

PRINCIPAL PURPOSE(S): To assist in determining possible third party liability for medical supplies and services claims under CHAMPUS. Information requested is used in reviewing claims to obtain additional information to determine proper liability of third parties for claims and to facilitate possible recovery by the United States for improperly paid claims.

ROUTINE USE(S): Information may be given to the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to members of Congress with the consent of the individual involved. Appropriate disclosures may be made to other Federal, state, local and/or foreign law enforcement agencies, private business entities, and individual providers of care, on matters 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 CHAMPUS.

DISCLOSURE: Voluntary; however, failure to provide information will result in a claims processing delay and may result in denial of the claim.

INSTRUCTIONS

According to information submitted with your recent CHAMPUS claim, you were treated for an injury of some kind. Because the claim form does not include information about how you were injured, we are asking that you also complete this form. The Federal Medical Recovery Act, 42 U.S.C. 2651-2653, allows the Government to be reimbursed for its costs of treating you, if you were injured in an accident caused by someone else. The Government can often recover its costs from (1) the person who caused the accident or that person's insurance company; or (2) the owner of the property where the accident occurred or the owner's insurance company. The Government may also be able to recover its costs from (1) any insurance company which insures your family for hospital and medical expenses; or (2) your employer's Worker's Compensation or other insurance, if you were injured at work.

If you were not treated for an injury, please describe the circumstances of your treatment in the Remarks section on Page 1. If you were treated for an injury but do not believe that someone else caused your injury, please describe in detail the circumstances surrounding your injury in the Remarks section on Page 2. If you use the Remarks section for either of these purposes, you do not need to complete the rest of the form. However, be sure to sign and return it according to the other instructions you have received.

This form is to be completed by persons who have received medical care at Government expense or by a responsible family member. In cases of young children, this form should be completed by a parent or guardian.

Answer all questions in as much detail as possible. The information you provide may be of great help to the Government and to you in recovering from the person who caused your injuries. We suggest you retain a copy of this form for your own use. If injury resulted from an automobile accident, you must attach a copy of the official police report to this form and complete Sections I, IV, and V. If injury did not result from an automobile accident, complete Sections I, III, and V.

The words "None," "N/A," and "Unknown" should be inserted where appropriate.

Attach additional sheets where necessary to provide complete information.

Complete all items to the best of your knowledge. **BE SURE TO SIGN AND DATE THE FORM ON PAGE 4. RETURN IT WITHIN 10 DAYS.**

IMPORTANT

This information is requested solely for the purpose of processing your CHAMPUS reimbursement claim. It has no bearing on any legal action you may pursue as a result of your injury. All questions you may have regarding possible legal actions should be referred to an attorney. Do not execute a release or settle any personal injury claim you may have without notice to a military claims officer.

SAMPLE—Do not use.

Current form can be found at www.triwest.com.

STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY
CHAMPUS

SECTION I - GENERAL INFORMATION

1. SPONSOR

a. SPONSOR'S NAME *(Last, First, Middle Initial)*	b. SSN

2. INJURED BENEFICIARY

a. INJURED BENEFICIARY'S NAME *(Last, First, Middle Initial)*	*b. AGE*	*c.* RELATIONSHIP TO SPONSOR *(X one)*
		☐ SELF ☐ NATURAL/ADOPTED CHILD ☐ STEPCHILD ☐ SPOUSE ☐ FORMER SPOUSE ☐ OTHER

d. HOME ADDRESS *(Street, Apartment Number, City, State, ZIP Code)*	e. SPONSOR'S ADDRESS *(If different from injured beneficiary's) (Street, Apartment Number, City, State, ZIP Code)*
TELEPHONE NO. *(Include Area Code)*	TELEPHONE NO. *(Include Area Code)*

SECTION II - REMARKS

3. USE THIS SECTION TO DESCRIBE IN YOUR OWN WORDS HOW YOU WERE INJURED.

SECTION III - NON-VEHICULAR ACCIDENTS
Complete if injuries did not result from a motor vehicle accident. If injuries resulted from a vehicular accident, go to Section IV.

4. LOCATION

a. SITE OF INJURY *(Street/Place, City, County, State)*	b. TIME *(Hour)* ☐ A.M. ☐ P.M.	c. DATE *(YYYYMMDD)*
d. NAME AND ADDRESS OF OWNER OF PROPERTY WHERE INJURY OCCURRED	e. NAME OF OCCUPANT OF PROPERTY *(If different from owner)*	

5. PERSONS INVOLVED

a. NAME *(Last, First, Middle Initial)*	*b. ADDRESS (Street, City, State, ZIP Code)* AND TELEPHONE NO. *(Include Area Code)*

SAMPLE—Do not use.

Current form can be found at www.triwest.com.

SECTION III - NON-VEHICULAR ACCIDENTS *(Continued)*

6. WITNESSES

a. NAME *(Last, First, Middle Initial)*	b. ADDRESS *(Street, City, State, Zip Code)* AND TELEPHONE NO. *(Include Area Code)*

7. POLICE INVESTIGATION

a. WAS AN INVESTIGATION CONDUCTED? *(If Yes, state by whom (e.g., City/State Police, Sheriff's Dept.)*	b. WAS ANYONE ARRESTED OR CITED AS CAUSING THE ACCIDENT? *(If yes, give name and charge)*	c. DISPOSITION OF CASE *(e.g., dismissal, fine, jail sentence)*
☐ YES ☐ NO	☐ YES ☐ NO	

d. EXPLAIN IN YOUR OWN WORDS WHO WAS AT FAULT AND WHY

e. WERE OTHER FAMILY MEMBERS INJURED IN THE ACCIDENT? *(If Yes, give name(s) and relationship)*

☐ YES
☐ NO

f. WAS THE ACCIDENT WORK RELATED? *(If Yes, state circumstances)*

☐ YES
☐ NO

8. INSURANCE

a. INSURANCE COMPANY OF OWNER OF PROPERTY WHERE INJURY OCCURRED *(e.g., Homeowner's Insurance Company)*	b. INSURANCE COMPANY OF PERSON WHO CAUSED ACCIDENT *(If different from item 8a.)*	c. YOUR OWN INSURANCE COMPANY
(1) COMPANY NAME	(1) COMPANY NAME	(1) COMPANY NAME
(2) ADDRESS *(Include ZIP Code)*	(2) ADDRESS *(Include ZIP Code)*	(2) ADDRESS *(Include ZIP Code)*
(3) POLICY NUMBER	(3) POLICY NUMBER	(3) POLICY NUMBER
(4) AMOUNTS AND TYPES OF COVERAGE	(4) AMOUNTS AND TYPES OF COVERAGE	(4) AMOUNTS AND TYPES OF COVERAGE

SAMPLE—Do not use.

Current form can be found at www.triwest.com.

SECTION IV - VEHICULAR ACCIDENT Attach a copy of the official police report to this form.

9. ADDITIONAL INFORMATION ON VEHICULAR ACCIDENT

a. INJURED BENEFICIARY'S AUTOMOBILE INSURANCE COMPANY	b. INSURANCE COMPANY'S ADDRESS *(Include ZIP Code)*
c. INSURANCE COMPANY TELEPHONE NO. *(Include Area Code)*	

d. POLICY NUMBER	e. AMOUNTS AND TYPE OF COVERAGE			
	(1) LIABILITY $	(2) MEDICAL PAYMENT $	(3) UNINSURED MOTORIST $	(4) NO FAULT $

f. WAS ACCIDENT REPORTED TO YOUR INSURANCE COMPANY? *(If No, explain)*	g. HAS YOUR INSURANCE COMPANY ASSIGNED A CLAIM OR FILE NUMBER? *(If Yes, provide number)*
☐ YES ☐ NO	☐ YES ☐ NO

h. WAS ACCIDENT WORK RELATED? *(If Yes, state circumstances)*

☐ YES
☐ NO

SECTION V - MISCELLANEOUS

10. GOVERNMENT HOSPITALIZATION. If you were hospitalized or expect to be hospitalized in a government hospital, complete the following:

a. NAME OF HOSPITAL	b. ADDRESS *(Include ZIP Code)*	c. DATES HOSPITALIZED *(YYYYMMDD)*		d. IS TREATMENT COMPLETED? *(X one)*	
		FROM	TO	YES	NO

11. YOUR ATTORNEY

a. ATTORNEY'S NAME	b. ADDRESS *(Street, City, State, ZIP Code)*
c. TELEPHONE NUMBER *(Include Area Code)*	

12. RELEASE STATEMENTS

a. HAVE YOU FURNISHED ANYONE OTHER THAN THE POLICE A STATEMENT AS TO WHAT HAPPENED? *(If Yes, to whom was it given?)*	b. HAVE YOU SIGNED ANY RELEASE OR WAIVER OF RIGHTS? *(If Yes, to whom was it given?)*
☐ YES ☐ NO	☐ YES ☐ NO
c. HAVE YOU RECEIVED ANY OFFER OF SETTLEMENT FOR YOUR INJURY? *(If Yes, from whom?)*	d. HAVE YOU ACCEPTED ANY SETTLEMENT? *(If Yes, from whom and how much?)*
☐ YES ☐ NO	☐ YES ☐ NO

SECTION VI - CERTIFICATION

13. I have completed this form and state that the information is true to the best of my knowledge and belief. Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious, or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

a. YOUR SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

SAMPLE—Do not use.

Current form can be found at www.triwest.com.

TRICARE Beneficiary Liability Form (Waiver of Limitation)

(NOT APPLICABLE TO ACTIVE DUTY SERVICE MEMBERS)

This waiver allows a non-network/non-contracted, non-participating provider to collect billed charges from a TRICARE beneficiary when the beneficiary has agreed, in writing, to waive his or her balance-billing protection.

I, _____, the TRICARE beneficiary, hereby agree to pay the full billed charges for the following service(s), regardless of the amount (if any) of the TRICARE program payment:

Date: _____ Service (Code): _____ [Estimated] Billed Charge:_____

Date: _____ Service (Code): _____ [Estimated] Billed Charge:_____

Date: _____ Service (Code): _____ [Estimated] Billed Charge:_____

TOTAL [ESTIMATED] BILLED CHARGES: _____

Note: This waiver applies to any and all services rendered by this provider, including, but not limited to office visits, office procedures, hospital visits, surgical fees.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) [estimated] above and will pay the provider this amount, regardless of any payment TRICARE may send to me. I understand that it is my choice to have these services provided at this time by a provider who is not participating in the TRICARE program.

_____

TRICARE BENEFICIARY SIGNATURE DATE

_____ _____

TRICARE BENEFICIARY NAME (PRINTED) SPONSOR SSN

_____

RELATIONSHIP TO SPONSOR

Providers must follow all proper coding regulations. If an appropriate CPT code exists that covers several procedures rendered, the provider must use the all-inclusive procedure code and not bill for each procedure separately. Reimbursement will be based on the all-inclusive procedure code.

PROVIDER NAME, ADDRESS
& PHONE NUMBER: _____

_____

_____

SAMPLE—Do not use.

Current form can be found at www.triwest.com.

TRICARE Beneficiary Liability Form (Waiver of Non-Covered Services)

(NOT APPLICABLE TO ACTIVE DUTY SERVICE MEMBERS)

This waiver allows a network (contracted) provider to collect billed charges for services denied as 'non-covered' (not a TRICARE benefit) from a TRICARE beneficiary when the beneficiary has agreed, in writing, to waive his or her balance-billing protection.

I, _____, the TRICARE beneficiary, hereby agree to pay the full billed charge(s) for the following service(s) denied as non-covered (not a TRICARE benefit) regardless of the fact the TRICARE program will not make payment:

Date: _____ Service (Code): _____ [Estimated] Billed Charge:_____

Date: _____ Service (Code): _____ [Estimated] Billed Charge:_____

Date: _____ Service (Code): _____ [Estimated] Billed Charge:_____

TOTAL [ESTIMATED] BILLED CHARGES: _____

Note: This waiver applies to any and all TRICARE non-covered services rendered by this provider, including, but not limited to office visits, office procedures, hospital visits, surgical fees.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) [estimated] for the services denied as non-covered (not a covered TRICARE benefit) and listed above and will pay the provider this amount, regardless of the fact TRICARE will not make payment. I understand that it is my choice to have these services provided at this time by this provider.

_____

TRICARE BENEFICIARY SIGNATURE DATE

_____ _____

TRICARE BENEFICIARY NAME (PRINTED) SPONSOR SSN

_____

RELATIONSHIP TO SPONSOR

Providers must follow all proper coding regulations. If an appropriate CPT code exists that covers several procedures rendered, the provider must use the all-inclusive procedure code and not bill for each procedure separately.

PROVIDER NAME, ADDRESS
& PHONE NUMBER: _____

_____

_____

SAMPLE—Do not use.

Current form can be found at www.triwest.com.

TRICARE Other Health Insurance (OHI) Form

REQUIRED FORM - TO BE COMPLETED BY THE OHI POLICY HOLDER

Instructions & Explanations for Completing the TRICARE Other Health Insurance Form

The information on this page is provided to help you complete the other health insurance (OHI) form on the back of this page. Please be sure to refer to this information for clarification when completing the form. This form is to be completed by the OHI policy holder.

Federal regulations require that you notify TRICARE if you are also the beneficiary of any OHI plan. Please note that TRICARE will provide you with benefits even if you have OHI. If you or your family members are currently receiving benefits through another health insurance plan, or have received OHI benefits in the past five years, you need to complete the form on the back of this page and return it to

TriWest Healthcare Alliance • P.O. Box 42048 • Phoenix, AZ 85080

If you decide to cancel your OHI, cancel with your carrier, complete an OHI form and mail it to TriWest.
Please note: Medicaid is not OHI and does not need to be reported.

Important Definitions and Information

Sponsor
The uniformed service member—either active duty, retired or deceased—whose relationship to you (spouse, parent, etc.) makes you eligible for TRICARE.

Beneficiary
Family members of active duty military personnel and military retirees and their families who are eligible for TRICARE benefits.

Health Maintenance Organization (HMO)
An HMO is a "prepaid" plan (such as TRICARE Prime) that uses a highly qualified, select network of health care providers. An HMO usually offers a full range of services, and often emphasizes preventive care.

Preferred Provider Organization (PPO)
A PPO (such as TRICARE Extra) is a network of health care providers who agree to provide patient care at a discounted or fixed cost to a health plan or beneficiaries in order to be a part of the network of providers. Generally, beneficiaries can choose from any of the providers in the network.

Basic Insurance
Insurance that usually carries a deductible and pays benefits according to a percentage plan. This could be any plan that is not a PPO or HMO.

Medicare
The national health program through which certain medical and hospital expenses are paid for from Federal (mainly Social Security) funds. The program is open to individuals over the age of 65 and individuals with permanent disabilities. If you are eligible for Part A, you **must** purchase Part B to retain TRICARE eligibility unless your sponsor is active duty.

Medicare Supplement
Medicare supplemental insurance, also called a Medigap policy, is a health insurance policy sold by private insurance companies to help you pay the medical costs the Original Medicare Plan does not cover. Medigap policies may be offered by organizations like USAA, TROA and AARP. Through supplemental insurance, you may be able to get extra benefits like prescription drugs or additional days in the hospital.

Privacy Act Statement
Authority: 10 U.S.C. Section 1086(d); 10 U.S.C. Section 1095; and E.O. 9397.

Purpose: Information provided is used to update your entitlement in the TRICARE program and to check or correct our records with respect to your Medicare and other health insurance coverage.

Routine Use(s): To the Social Security Administration to verify an applicant's eligibility; to the Department of Health and Human Services consistent with their statutory responsibilities for monitoring Government health care programs; and, to health insurance providers for coordination of coverage benefits.

Disclosure: Voluntary; however, failure to provide requested information may cause delay in payment of your medical claims.

Agency Disclosure Notice
The public reporting burden for this collection of information is estimated to average five minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to DoD, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0025), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA, 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

If you have questions about this form or need an additional form, please call TriWest at 1-888-TRIWEST (874-9378).

SAMPLE—Do not use.

Current form can be found at www.triwest.com.

TRICARE Other Health Insurance Form

REQUIRED FORM - TO BE COMPLETED BY THE OHI POLICY HOLDER

Section I: Personal Information

Beneficiary's Social Security number:	Beneficiary's date of birth:
Beneficiary's last name:	Beneficiary's first name & middle initial:
Sponsor's Social Security number:	Sponsor's date of birth:
Sponsor's last name:	Sponsor's first name & middle initial:

Sponsor's mailing address:	City	State	ZIP

Sponsor's home telephone number:	Sponsor's work telephone number:	Sponsor's e-mail address:

Section II: OHI Information

Does anyone in your family have OHI? ❑ YES ❑ NO	If yes, what is the coverage type (*See cover page for details*)? ❑ HMO ❑ PPO ❑ Basic Insurance ❑ Medicare ❑ Medicare Supplement	
Does this OHI include pharmacy benefits? ❑ YES ❑ NO	Does this OHI include any mental health benefits? ❑ YES ❑ NO	Is this OHI through sponsor's employer or spouse's employer? ❑ Sponsor's employer ❑ Spouse's employer

OHI policy holder's name:	Relationship to sponsor:
Names of anyone else covered under this policy: 1.	2.
3.	4.

If OHI is through an employer, please provide:	Name of insurance company:

Insurance company address:	City	State	ZIP
Employer name:			
Employer address:	City	State	ZIP

Policy number:	Group number:	Effective date:	Termination date:

Section III: Medicare Information

Complete the following if you have Medicare coverage:	Medicare health insurance number:	Effective date-Hospital (Part A):	Effective date-Medical (Part B):

Section IV: Authorization

The statements made above are true and correct to the best of my knowledge. I understand Federal Law 18 U.S.C. 1001 provides for criminal penalties for submitting or making false, fictitious or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the law cited may be obtained from the Uniformed Services legal offices, public libraries and any beneficiary counseling and assistance coordinator.

Your signature:	
Relationship to sponsor:	Today's date:

Please complete this form and mail it to TriWest at

TriWest Healthcare Alliance • P.O. Box 42048 • Phoenix, AZ 85080

JT# BE-FR-MISC-6-1 04/03

AN IMPORTANT MESSAGE FROM TRICARE

YOUR RIGHTS WHILE A TRICARE HOSPITAL PATIENT

You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs, not by DRGs or by TRICARE payments.

You have the right to be fully informed about decisions affecting your TRICARE coverage and payment of your hospital stay and any post-hospital services.

You have the right to request a review by the TRICARE MANAGED CARE SUPPORT CONTRACTOR of any written notice of non-coverage that you may receive from the hospital stating that TRICARE will no longer pay for your hospital care. The contractors utilize groups of doctors under contract by the Federal government to review medical necessity, appropriateness and quality of hospital treatment furnished to TRICARE patients. The phone number and address of the TRICARE MANAGED CARE SUPPORT CONTRACTOR for your area is:

TriWest Healthcare Alliance Corp.
ATTN: Reconsideration Unit
P.O. Box 42049
Phoenix, AZ 85080
1-888-TriWest (874-9378)

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL
You and your doctor know more about your condition and your health than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge, your need for possible post-hospital care, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON
Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "notice of non-coverage." You must have notice of non-coverage if you wish to exercise your right to request a review by the TRICARE MANAGED CARE SUPPORT CONTRACTOR.

The notice of non-coverage will state whether your doctor or the TRICARE MANAGED CARE SUPPORT CONTRACTOR agrees with the hospital's decision that TRICARE should no longer pay for your hospital care.

- If the hospital and your doctor agree, the TRICARE MANAGED CARE SUPPORT CONTRACTOR does not review your case before a notice of non-coverage is issued. But the TRICARE MANAGED CARE SUPPORT CONTRACTOR will respond to your request for a review of your notice of non-coverage and seek your opinion. You cannot be made to pay for your hospital care until the TRICARE MANAGED CARE SUPPORT CONTRACTOR makes its decision, if you request the review by noon of the first work day after you receive the notice of non-coverage.
- If the hospital and your doctor disagree, the hospital may request the TRICARE MANAGED CARE SUPPORT CONTRACTOR to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation the TRICARE MANAGED CARE SUPPORT CONTRACTOR must agree with the hospital or the hospital cannot issue a notice of non-coverage, but since the TRICARE MANAGED CARE SUPPORT CONTRACTOR has already reviewed your case once, you may have to pay for at least one day of hospital care before TRICARE MANAGED CARE SUPPORT CONTRACTOR completes this reconsideration.

AN IMPORTANT MESSAGE FROM TRICARE

IF YOU DO NOT REQUEST A REVIEW, THE HOSPITAL MAY BILL YOU FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE NOTICE ON NON-COVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDES YOU WITH A NOTICE OF NON-COVERAGE**.**

HOW TO REQUEST A REVIEW OF THE NOTICE OF NON-COVERAGE

If the notice of non-coverage states that your physician agrees with the hospital's decision:

- You must make your request for review to the TRICARE MANAGED CARE SUPPORT CONTRACTOR by noon of the first work day after you receive the notice of non-coverage by contacting the TRICARE MANAGED CARE SUPPORT CONTRACTOR by phone or in writing.
- The TRICARE MANAGED CARE SUPPORT CONTRACTOR must ask for your view about your case before making its decision. The TRICARE MANAGED SUPPORT CONTRACTOR will inform you by phone and in writing of its decision on the review.
- If the TRICARE MANAGED CARE SUPPORT CONTRATOR agrees with the notice of non-coverage, you may be billed for all costs of your stay beginning at noon of the day after you receive the TRICARE MANAGED CARE SUPPORT CONTRACTOR's decision.
- Thus, you will not be responsible for the cost of hospital care before you receive the TRICARE MANAGED CARE SUPPORT CONTRACTOR DECISION.

If the notice of non-coverage states that the TRICARE MANAGER CARE SUPPORT CONTRACTOR agrees with the hospital decision:

- You should make your request for reconsideration BY IDENTIFYING THIS TO THE TRICARE MANAGED CARE SUPPORT CONTRACTOR immediately upon receipt of the notice of non-coverage by contacting the TRICARE MANAGED CARE SUPPORT CONTRACTOR in writing. The TRICARE MANAGED CARE SUPPORT CONTRACTOR will forward the request and medical record documentation to the appropriate NATIONAL QUALITY MONITORING CONTRACOR for a reconsideration.
- The NATIONAL QUALITY MONITORING CONTRACTOR can take up to three working days from receipt of your request to complete a review. The NATIONAL QUALITY MONITORING CONTRACTOR will inform you in writing of its decision on the review.
- Since the TRICARE MANAGED CARE SUPPORT CONTRACTOR has already reviewed your case once prior to the issuance of the notice of non-coverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your notice of non-coverage, even if the NATIONAL QUALITY MONITORING CONTRACTOR has not completed its review.
- Thus, if the NATIONAL QUALITY MONITORING CONTRACTOR continues to agree with the notice of non-coverage, you may have to pay for at least one day of hospital care.

NOTE:

The process described above is called "immediate review." If you miss the deadlines for this immediate review while you are in the hospital, you may still request a review of the TRICARE decision to no longer pay for your care at any point during your hospital stay or after you have left the hospital. The notice of non-coverage will tell you how to request this review.

POST-HOSPITAL CARE

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or to home care. The discharge planner at the hospital will help arrange for the services that you may need after discharge.

AN IMPORTANT MESSAGE FROM TRICARE

TRICARE and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult your doctor, hospital discharge planner, health benefits advisor, or patient representative and your family in making preparations for care after you leave the hospital. Don't hesitate to ask questions.

Questions involving billing or specific benefit coverage issues should be addressed to your TRICARE claims processor, which is:

Wisconsin Physician Services (WPS)
Toll-Free Phone Number: 1-888-874-9378

ACKNOWLEDGEMENT OF RECEIPT

My signature only acknowledges my receipt of this message from (Name of Hospital) on (Date) and does not waive any of my rights to request a review or make me liable for any payment.

_____
Signature of Beneficiary of Person Acting on Behalf of the Beneficiary

_____
Date Signed

Notes

1-888-TRIWEST
www.triwest.com

TriWest Healthcare Alliance
1-888-TRIWEST (1-888-874-9378)

Wisconsin Physicians Service (WPS) Electronic Claims
1-800-782-2620

WPS TRICARE For Life
1-866-773-0404

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