Introduction to TRICARE®

Provider Orientation for Physicians & Facilities

Humana Military

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TRICARE and the South Region

Humana Military

What is TRICARE?

TRICARE is the Department of Defense (DoD) worldwide health care program available to eligible beneficiaries in the uniformed services:

- U.S. Army
- U.S. Navy
- U.S. Air Force
- U.S. Marine Corps
- U.S. Coast Guard
- Commissioned Corps of the U.S. Public Health Service
- Commissioned Corps of the National Oceanic and Atmospheric Administration

TRICARE-eligible beneficiaries may include:

- Active Duty Service Members (ADSMs)
- Active Duty Family Members (ADFMs)
- Retired service members and their families
- National Guard and Reserve members and their families
- Survivors
- Certain former spouses and others

TRICARE Management Authority (TMA) Quadruple Aim

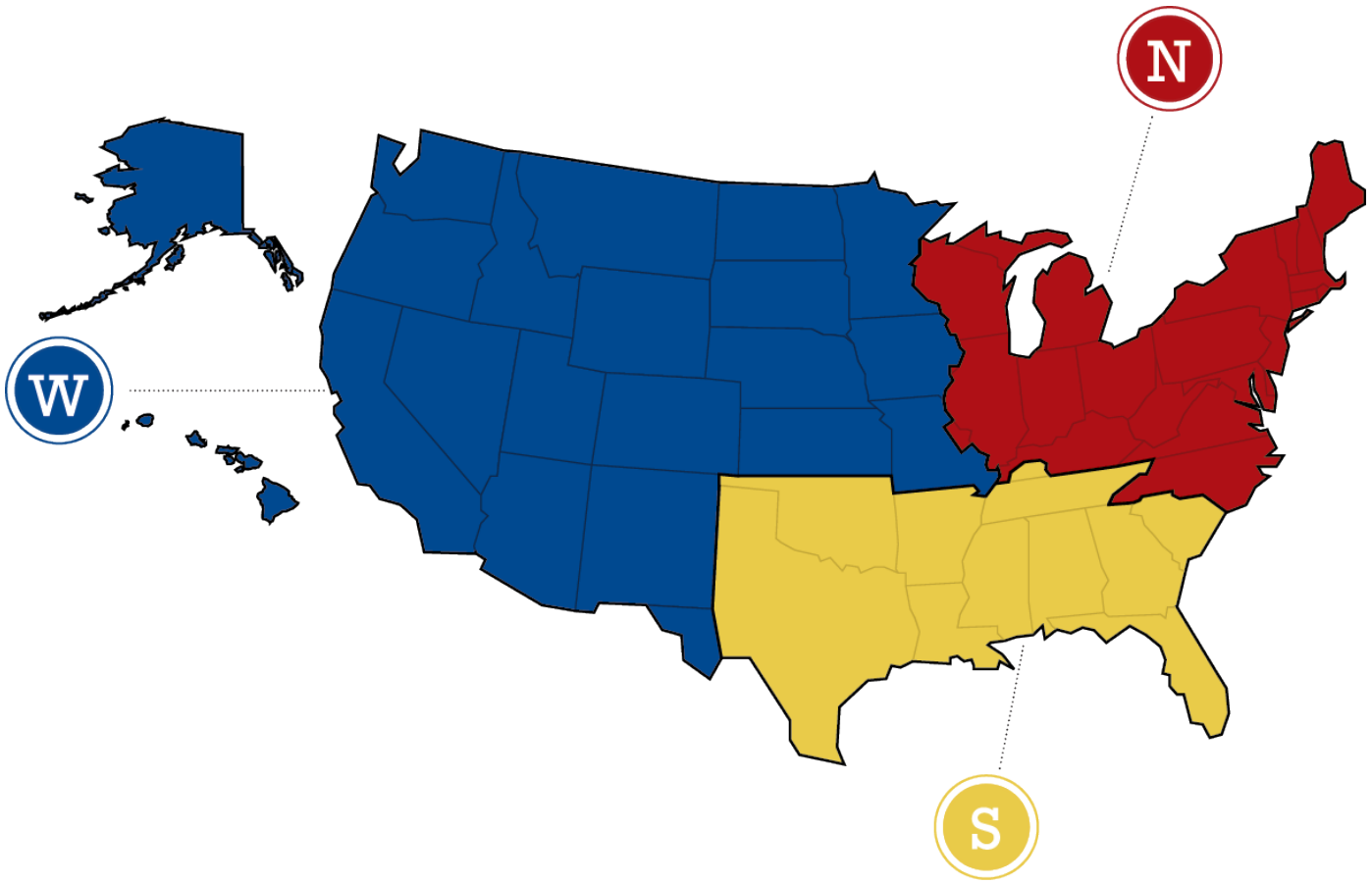
Better Care:
Defined as providing patient and family centered, compassionate, convenient, equitable, safe, always of highest quality

Readiness:
Defined as ensuring the total military force Is medically ready to deploy

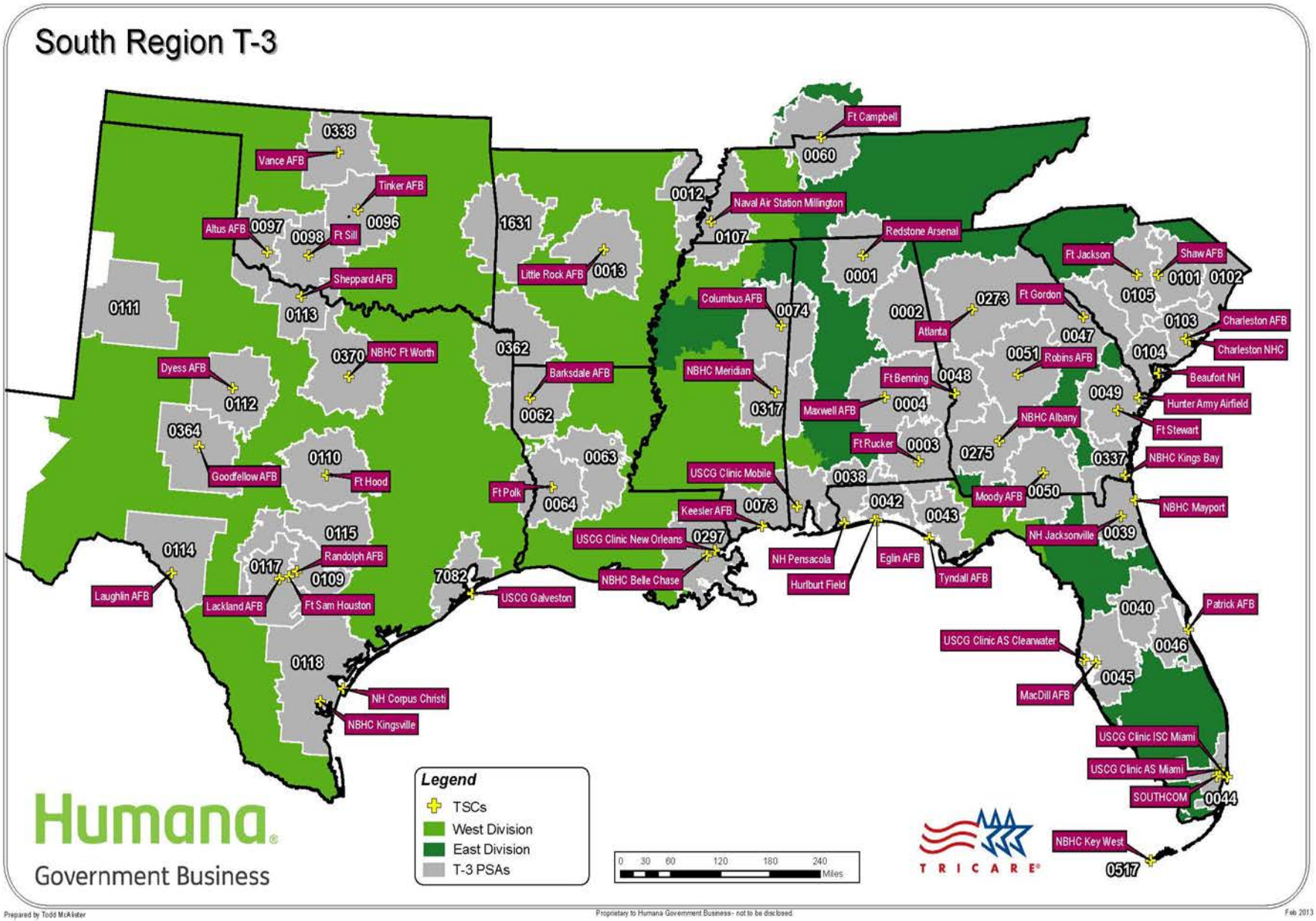
Better Health:
Defined as reducing generators of ill health by encouraging healthy behaviors and decreasing likelihood of Illness through focused prevention and increased resilience

Lower Cost::
Defined as creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering total cost of care over time

TRICARE Regions:
North, West and South



TRICARE South Region



Humana Military's Role

- Managed Care Support Contractor (MCSC) for the TRICARE South Region since 1996
- TRICARE Service Centers (TSCs) available to beneficiaries throughout the South Region co-located where a military base or post exists
- Serving approximately 3,000,000 eligible beneficiaries in the South Region alone

Humana Military Partners

PGBA, LLC is Humana Military's claims processing partner in the South Region

- PGBA is a fiscal intermediary for the military's TRICARE health benefits program and is one of the largest subsidiaries of BlueCross BlueShield of South Carolina

ValueOptions®, Inc. is Humana Military's behavioral health partner in the South Region

- ValueOptions is the nation's largest independent behavioral health care and wellness company, specializing in management for all behavioral health issues and mental health and chemical dependency diagnoses

Provider Information

Humana Military

Rules and Regulations

- TRICARE providers must abide by the rules, procedures, policies and program requirements specified in the ***TRICARE Provider Handbook*** provided as part of a network contract (The handbook is updated and re-issued to all providers annually)
- An online version of the *TRICARE Provider Handbook* is available at Humana-Military.com

- TRICARE-related statutes are in **Chapter 55 of Title 10 of the United States Code**, which contains all statutes regarding the armed forces
- Find TRICARE manuals at http://manuals.tricare.osd.mil

- ***TRICARE Provider News***, published quarterly, includes information about policy changes, timely notifications and implementation guidance

TRICARE Certification

- **TRICARE only reimburses appropriate covered services for eligible beneficiaries provided by TRICARE-authorized providers**
- TRICARE-authorized providers must meet TRICARE licensing and certification standards
- TRICARE-authorized providers must comply with regulations specific to their health care areas
- **KePRO, the TRICARE Quality Monitoring Contractor (TQMC), must certify freestanding Partial Hospitalization Programs (PHPs), Residential Treatment Centers (RTCs) and Substance Use Disorder Rehabilitation Facilities (SUDRFs) Call 1-877-841-6413**
- When a hospital is a TRICARE-authorized provider, the hospital's PHP is also a TRICARE-authorized provider

TRICARE Credentialing

- **To join the TRICARE network:** A TRICARE-authorized provider must complete the credentialing process and sign a contract with Humana Military or ValueOptions for behavioral health
- **Credentialing is also required for:** Acute inpatient facilities, freestanding surgical centers, home health agencies and skilled nursing facilities
- **Minimum credentialing criteria include**:
  - Current signature and date on the application
  - Current, valid, unrestricted and unprobated state license
  - Current acceptable liability insurance
  - Ability to participate in federal health care programs, including Medicare, Medicaid and all other plans and programs that provide health benefits funded by the United States (excluding the Federal Employees Health Benefits Plan)
  - Acceptable accreditation status appropriate to the facility

Specialty Care and Emergency Care Responsibilities

Specialty care may require prior authorization from Humana Military as well as referrals from Primary Care Managers (PCMs) and/or Humana Military

- TRICARE Prime beneficiaries living within a 60-minute drive time of a Military Treatment Facility (MTF) may be required to first seek specialty care, ancillary services and physical therapy at the MTF based on the Right Of First Refusal (ROFR)
- PCMs and specialty care providers must coordinate with Humana Military to obtain referrals and prior authorizations
- Submitting a claim for an unauthorized service is subject to a penalty of up to 50 percent of the TRICARE-allowable charge
- To avoid penalties, providers must notify Humana Military of any emergency admissions by visiting Humana-Military.com, calling 1-800-444-5445 or faxing 1-877-548-1547

Balance Billing and the Hold Harmless Policy

- **Network and participating non-network providers agree to accept the TRICARE-allowable charge as payment in full for a covered service**
- Providers may not bill TRICARE beneficiaries more than this amount for covered services
- Non-network, nonparticipating providers do not have to accept the TRICARE-allowable charge and may bill patients for up to 15 percent above
- If patients have Other Health Insurance (OHI), providers must bill the OHI first. Providers may not collect more than the billed charge from the OHI and TRICARE combined
- Balance billing limitations apply only to TRICARE-covered services
- Network providers must notify patients if TRICARE does not cover a service
- **They may direct bill a beneficiary for excluded services based on the examples below:**
  - If the beneficiary failed to inform the provider about his or her TRICARE coverage
  - If the beneficiary is aware that TRICARE does not cover the service and agrees to pay for the services in advance by signing the *TRICARE Non-Covered Services Waiver* form, available on Humana Military's website
- If the TRICARE beneficiary has not signed the *TRICARE Non-Covered Services Waiver* form, he or she is held harmless from financial liability

TRICARE Options

Humana Military

Verifying Eligibility

Providers must verify TRICARE eligibility prior to or at the time of service using valid Common Access Cards (CACs), uniformed services ID cards or eligibility authorization letters

- A CAC or ID card alone does not prove eligibility
- Confirm eligibility by going to Humana-Military.com
- Use the sponsor's Social Security Number (SSN) or DoD Benefits Number (DBN) to verify beneficiary eligibility(See Verifying Patient Eligibility Presentation for directions)

COMMON ACCESS CARD (CAC)

DoD Benefits Number
(only on cards that convey DoD benefits)

ALL OTHER CARDS

DoD Benefits Number
(only on cards that convey DoD benefits)

TRICARE and Veterans Affairs Benefits

Certain beneficiaries are eligible for both TRICARE and U.S. Department of Veterans Affairs (VA) benefits programs, and they may choose which benefits they want to use

- Beneficiaries may seek TRICARE-covered services even if they received treatment through the VA for the same medical condition during a previous episode of care

- TRICARE does not duplicate payments made or authorized by the VA for service-connected disability care

- For beneficiaries not eligible for Medicare, VA coverage is considered OHI, and TRICARE pays second to any out-of-pocket costs for VA services

TRICARE Prime

ADSMs living and working in PSAs must enroll in TRICARE Prime

- Managed care option available in TRICARE Prime Services Areas (PSAs), requires a Primary Care Manager (PCM)
- ADFMs can choose TRICARE Prime or use TRICARE Standard and if seeing network providers-TRICARE Extra
- PRIME typically requires referrals and/or authorizations for nonemergency care outside of PCM office
- Military Treatment Facilities generally have beneficiaries enrolled to a PCM at the local (MTF) where possible
- MTFs have Right Of First Refusal
- TRICARE Prime beneficiaries must first seek care at the MTF

TRICARE Standard and TRICARE Extra

TRICARE Standard: Fee-for-service option that allows beneficiaries to seek care from any TRICARE-authorized provider

TRICARE Extra: Preferred provider option of TRICARE Standard that allows beneficiaries to reduce out of pocket cost by visiting network providers

- Available to all eligible beneficiaries *except* ADSMs
- Standard involves annual deductibles and cost-shares
- Does not require PCM assignment and allows beneficiaries to self-refer
- Standard requires certain services obtain prior authorization approval (inpatient admissions for substance abuse disorders and behavioral health, adjunctive dental care, home health services)

TRICARE For Life and Medicare Eligibility

- **TRICARE For Life (TFL)** is Medicare wraparound coverage available to any TRICARE beneficiary who has Medicare Part A and Medicare Part B
- ADFMs entitled to Medicare Part A do not have to have Medicare Part B to be TRICARE-eligible **as long as** the sponsor is on Active Duty
- Beneficiaries receiving disability benefits from the Social Security Administration (SSA) are entitled to Medicare in the 25th month of receiving disability payments
- When disability payments are suspended, beneficiaries must continue to pay Medicare Part B premiums to remain eligible for TRICARE coverage
- Beneficiaries can seek care from any Medicare-participating provider, nonparticipating provider, opt-out provider, MTF (on a space-available basis) or a Veterans Affairs (VA) facility

TRICARE Pharmacy Program

- Comprehensive prescription drug coverage, administered **by Express Scripts, Inc.**
- **All TRICARE beneficiaries are eligible**
- Beneficiaries can fill prescriptions at MTF pharmacies, TRICARE Pharmacy Home Delivery, TRICARE retail network pharmacies or non-network retail pharmacies
- TRICARE has established quantity limits on certain medications
- Some drugs require prior authorization from Express Scripts
- Visit http://pec.ha.osd.mil and select Formulary Search Tool to check for restrictions on a medication

Specialty Medication Care Management Program

Seeks to improve beneficiaries' health through continuous health evaluation, ongoing monitoring, assessment of educational needs and management of medication use

- Provides monthly refill reminder calls, scheduled deliveries, specialty consultations with a nurse or pharmacist, and access to proactive, clinically based services for specific diseases
- Patients who receive medications through TRICARE Pharmacy Home Delivery receive these services at no additional cost, and participation is voluntary
- Specialty medications are usually high-cost; self-administered; injectable, oral or infused drugs that treat serious chronic conditions
- They typically require special storage and handling, are not readily available at local pharmacies and may have side effects that require pharmacist and/or nurse monitoring

Cancer Clinical Trials

Participation in cancer clinical trials became a permanent TRICARE benefit April 1, 2008

Three types of National Cancer Institute (NCI) clinical trials:

- **Phase I:** Beneficiaries may be eligible to participate in Phase I trials if they meet certain requirements
- **Phase II:** Beneficiaries may participate in these trials, which study the safety and efficacy of an agent or intervention on a particular type of cancer and evaluate its effect on the human body
- **Phase III:** Beneficiaries may participate in these trials, which compare promising new treatments for a particular type of cancer against standard approaches

- TRICARE cost-shares all medical care and testing required to determine eligibility for an NCI-sponsored trial
- Participation in NCI clinical trials requires prior authorization
- Providers must contact a case manager before beginning any evaluation or treatment

TRICARE Extended Care Health Option (ECHO)

Provides services to ADFMs who qualify based on specific mental or physical disabilities

- Offers an integrated set of services and supplies beyond those provided by basic TRICARE programs
- Only available to those registered in the Exceptional Family Member Program (EFMP)
- **Qualifying conditions:**
  - Moderate or severe mental retardation
  - Serious physical disability
  - Multiple disabilities affecting separate body systems
- Also available to children under age three diagnosed with a neuromuscular developmental condition or other condition expected to precede diagnosis of a condition listed above

Medical Coverage

Humana Military

Prior Authorization List for the South Region

SERVICES REQUIRING PRIOR AUTHORIZATION IN THE SOUTH REGION [1]

PROCEDURES AND SERVICES

- Adjunctive dental care
- Advanced life support air ambulance in conjunction with stem cell transplantation
- Bariatric surgery
- Department of Defense (DoD) In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial
- Educational interventions under the DoD Enhanced Access to Autism Services Demonstration
- Extended Care Health Option services
- Home health services, including home infusion
- Hospice
- Phase II and Phase III cancer clinical trials

INPATIENT HOSPITAL STAYS

- Admissions or transfers to skilled nursing facilities, rehabilitation, and long-term acute care
- Discharge notification
- Notification of acute care admission by the next working day

BEHAVIORAL HEALTH

- All nonemergency inpatient admissions for behavioral health care or substance use disorder
- Partial hospitalization programs (*psychiatric and substance use disorder*)
- Psychoanalysis
- Residential treatment center programs
- Outpatient behavioral health visits exceeding the initial eight visits each fiscal year (October 1-September 30).

1. The list of services requiring prior authorization changes periodically. For the most current list, go to ***www.humana-military.com****.*
The information contained in these charts is ***not*** *all-inclusive.*

Inpatient Services

- Hospital, general nursing, physician and surgical services
- Meals, including special diets
- Drugs and medications
- Operating and recovery room care
- Anesthesia
- Laboratory tests, X-ray services and other radiology services
- Medical supplies and appliances
- Blood and blood products
- Semiprivate rooms and special care units if medically necessary
- Surgical procedures designated as “inpatient only” **only** when performed in an inpatient setting
- Skilled nursing facility care
- Bariatric surgery
- Behavioral health care services, including acute inpatient psychiatric care, partial hospitalization program care, residential treatment center care and substance abuse services

Hospitalization

All non-urgent hospital admissions require prior authorization

- Humana Military must be notified of all emergency inpatient admissions within 24 hours or the next business day
- A Last Covered Date (LCD) is assigned at time of approval for inpatient medical/surgical non-active duty admissions
- The LCD is the last day of the inpatient admission to be paid the full allowable amount
- Hospitals must request extensions of approved days when needed
- Financial penalties will be applied to claim reimbursement for any unauthorized day(s)

An Important Message from TRICARE

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 a TRICARE Regional Review Authority (RRA) of any written notice of noncoverage that you may receive from the hospital stating that TRICARE will no longer pay for your hospital care. The RRA employs 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 your RRA is:

Humana Military Healthcare Services, Inc.
Utilization Management
P.O. Box 740044
Louisville, KY 40201-9973
1-800-334-5612

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL

You and your doctor know more about your condition and your health needs 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, or 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 noncoverage." You must have this notice of noncoverage if you wish to exercise your right to request a review by the RRA.

The notice of noncoverage will state whether your doctor or the RRA agrees with the hospital's decision that TRICARE should no longer pay for your hospital care.

* If the hospital and your doctor agree, the RRA does not review your case before a notice of noncoverage is issued. But the RRA will respond to your request for a review of your notice of noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the RRA makes its decision, if you request the review by noon of the first work day after you receive the notice of noncoverage.

* If the hospital and your doctor disagree, the hospital may request the RRA 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 RRA must agree with the hospital or the hospital cannot issue a notice of noncoverage. You may request that the RRA reconsider your case after you receive a notice of noncoverage but since the RRA has already reviewed your case once, you may have to pay for at least one day of hospital care before the RRA completes this reconsideration.

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 OF NONCOVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDES YOU WITH A NOTICE OF NONCOVERAGE.

(over, please)

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

If the notice of noncoverage states that your physician agrees with the hospital's decision:

* Call the RRA at 1-800-658-1405 by noon of the first work day after you receive the notice of noncoverage and request a review.

* The RRA must ask for your views about your case before making its decision. The RRA will inform you by phone and in writing of its decision on the review.

* If the RRA agrees with the notice of noncoverage, you may be billed for all the cost of your stay beginning at noon of the day after you receive the RRA's decision.

* Thus, you will not be responsible for the cost of hospital care before you receive the RRA's decision.

If the notice of noncoverage states that the RRA agrees with the hospital's decision:

* You should make your request for reconsideration to the RRA immediately upon receipt of the notice of noncoverage by contacting the RRA in writing.

* The RRA can take up to three working days from receipt of your request to complete a review. The RRA will inform you in writing of its decision on the review.

* Since the RRA has already reviewed your case once prior to the issuance of the notice of noncoverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after your receive your notice of noncoverage, even if the RRA has not completed its review.

* Thus, if the RRA continues to agree with the notice of noncoverage, 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 deadline 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 noncoverage 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 you may need after your discharge. 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 with your doctor, hospital discharge planner, health benefits advisor, 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:

Palmetto Government Benefits Administrators (PGBA)
Correspondence
P.O. Box 7032
Camden, SC 29020-7032
1-800-403-3950

Acknowledgment 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 or Person Acting on Behalf of the Beneficiary — Date Signed

Hospitalization

Discharge planning:

- Helps eliminate barriers that may disrupt a timely discharge from the acute care setting
- Discharge planning begins on admission review and continues throughout the hospital stay
- Includes arranging for services such as home health care and durable medical equipment needed after discharge

Maternity Care

TRICARE covers medical services related to prenatal care, labor and delivery, and postpartum care

- PCM must submit a referral prior to the beneficiary's first obstetrics appointment
- The referral begins with the first prenatal visit and is valid through 42 days after birth
- PCM must request prior authorization for delivery in a civilian inpatient facility or birthing center
- PCM must notify Humana Military of any hospitalization or observation during pregnancy
- TRICARE covers medically necessary fetal ultrasounds
- See handbook for a list of specific coverage and limitations

Hospice Care

Four levels of care: Continuous home care, general hospice inpatient care, inpatient respite care and routine home care

- **Care only begins with a doctor's order and requires prior authorization**
- **Hospice care is provided in three benefit periods:** The first two are 90 days each, and the final period comprises an unlimited number of 60-day periods (each requires recertification of terminal illness)
- **Care may include:** Physician services, nursing care, counseling, medical equipment, supplies, medications, medical social services, physical and occupational services, speech and language pathology, and hospice short-term acute patient care
- Only includes room and board if patient is receiving inpatient or respite care

Outpatient Services

TRICARE covers:

- Adjunctive dental care
- Ambulance services
- Durable Medical Equipment (DME), prosthetics, orthotics and supplies
- Home health care
- Laboratory and X-ray services
- Individual provider services
- Behavioral health services, including outpatient psychotherapy, psychological testing and assessment, medication management, Telemental Health Program and Smoking Cessation Program

Physical, Speech and Occupational Therapy

Therapy services are a covered benefit

- Referral requests are submitted by the PCM or a qualified specialist such as an Orthopedic Surgeon for PT
- The number of therapy visits are approved based on the diagnosis and treatment, with additional visits allowed with the appropriate documentation
- PT, ST, and OT are considered “Allied Health” providers and are not credentialed

Limitations and Exclusions

- **To determine if a specific service is a covered benefit or coverage is limited, check the current list of noncovered services on the No Government Pay Procedure Code List at** www.tricare.mil/nogovernmentpay

- ***TRICARE Provider Handbook* references:**
  - Med/Surg limitations
  - Med/Surg exclusions
  - Behavioral health limitations and exclusions

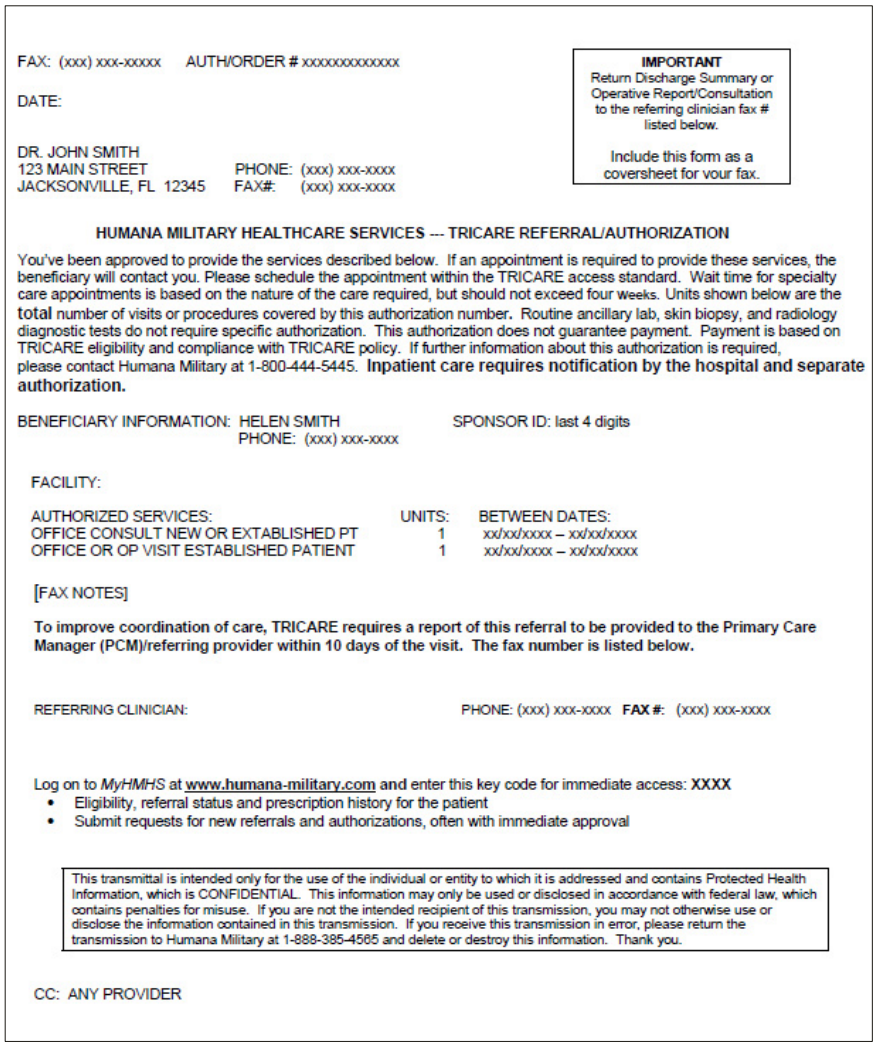
Health Care Management and Administration

Humana Military

Referrals and Authorizations

Refer only if requested service is not available at the MTF or PCM's office

- **Submit referral and authorization requests online at:** Humana-Military.com (see Referrals & Auths: Creating a New Request Presentation for directions)
- Most requests are processed within 24 hours or less when done online
- PCM and referred-to provider will receive an automatic fax when care is authorized (at right)
- Learn how to check status or update a request with the Updating a Request for Referrals/Authorizations Presentation



FAX: (xxx) xxx-xxxx AUTH/ORDER # xxxxxxxxxxxx

DATE:

IMPORTANT
Return Discharge Summary or Operative Report/Consultation to the referring clinician fax # listed below.

Include this form as a coversheet for your fax.

DR. JOHN SMITH
123 MAIN STREET PHONE: (xxx) xxx-xxxx
JACKSONVILLE, FL 12345 FAX#: (xxx) xxx-xxxx

HUMANA MILITARY HEALTHCARE SERVICES --- TRICARE REFERRAL/AUTHORIZATION

You've been approved to provide the services described below. If an appointment is required to provide these services, the beneficiary will contact you. Please schedule the appointment within the TRICARE access standard. Wait time for specialty care appointments is based on the nature of the care required, but should not exceed four weeks. Units shown below are the total number of visits or procedures covered by this authorization number. Routine ancillary lab, skin biopsy, and radiology diagnostic tests do not require specific authorization. This authorization does not guarantee payment. Payment is based on TRICARE eligibility and compliance with TRICARE policy. If further information about this authorization is required, please contact Humana Military at 1-800-444-5445. **Inpatient care requires notification by the hospital and separate authorization.**

BENEFICIARY INFORMATION: HELEN SMITH SPONSOR ID: last 4 digits
PHONE: (xxx) xxx-xxxx

FACILITY:

AUTHORIZED SERVICES:	UNITS:	BETWEEN DATES:
OFFICE CONSULT NEW OR EXTABLISHED PT	1	xx/xx/xxxx – xx/xx/xxxx
OFFICE OR OP VISIT ESTABLISHED PATIENT	1	xx/xx/xxxx – xx/xx/xxxx

[FAX NOTES]

To improve coordination of care, TRICARE requires a report of this referral to be provided to the Primary Care Manager (PCM)/referring provider within 10 days of the visit. The fax number is listed below.

REFERRING CLINICIAN: PHONE: (xxx) xxx-xxxx **FAX #:** (xxx) xxx-xxxx

Log on to *MyHMHS* at **www.humana-military.com** and enter this key code for immediate access: **XXXX**
- Eligibility, referral status and prescription history for the patient
- Submit requests for new referrals and authorizations, often with immediate approval

This transmittal is intended only for the use of the individual or entity to which it is addressed and contains Protected Health Information, which is CONFIDENTIAL. This information may only be used or disclosed in accordance with federal law, which contains penalties for misuse. If you are not the intended recipient of this transmission, you may not otherwise use or disclose the information contained in this transmission. If you receive this transmission in error, please return the transmission to Humana Military at 1-888-385-4565 and delete or destroy this information. Thank you.

CC: ANY PROVIDER

Referrals and Authorizations

- **Some referrals may be authorized from one specialty care provider to another, bypassing the need for another PCM referral:** These referrals apply only when a valid Evaluate and Treat referral from the PCM was previously authorized for the same episode of care
- Specialist-to-specialist referrals are not allowed for ADSMs
- **Referrals or authorizations are not required for emergency care, but:** TRICARE Prime beneficiaries must contact Humana Military or ValueOptions within 24 hours of an inpatient admission, or the next business day, to coordinate ongoing care
- Referrals are required when TRICARE Prime beneficiaries seek urgent care
- Without an approved referral, PRIME claims will process under the Point-Of-Service (POS) option (this is an out of pocket penalty)
- Beneficiaries should receive all routine care from network providers in their designated regions
- When receiving routine care in another region, TRICARE Prime beneficiaries need referrals from their PCMs or regional contractors

Medical Records Documentation

Humana Military may review a provider's medical records on a random basis to evaluate patterns of care and compliance

- Policies and procedures should be in place to help ensure a beneficiary's medical record is kept organized and confidential
- Medical records must contain information to justify admission and continued hospitalization, support the diagnosis and describe the patient's progress and response to medications and services

Utilization Management

- **Also known as prior authorizations:** prospective reviews ensure requested services are medically necessary and provided in the appropriate setting
- **Concurrent reviews evaluate continued inpatient stay to determine medical necessity, quality of care and appropriateness of the level of care being provided:** These reviews ensure appropriate, efficient and effective utilization of medical resources
- Retrospective reviews occur when a certain procedure or service requires a medical necessity review but was not previously authorized

Fraud and Abuse

TMA oversees the fraud and abuse program for TRICARE

- The Program Integrity Branch analyzes and reviews cases of potential fraud (i.e., the intent to deceive or misrepresent to secure unlawful gain) and abuse (i.e., practices inconsistent with sound fiscal, business or medical procedures and services not considered to be reasonable and necessary)
- Fraudulent actions can result in criminal or civil penalties
- Fraudulent or abusive activities may result in administrative sanctions, including suspension or termination as a TRICARE-authorized provider
- Report suspected fraud and abuse to the Humana Military Fraud and Abuse Hotline at **1-800-333-1620**

Claims and Billing

Humana Military

HIPAA National Provider Identifier Compliance

TRICARE requires providers to electronically file claims that are compliant with the appropriate Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard electronic claims format

- All covered entities must use their National Provider Identifiers (NPIs) and submit NPIs on HIPAA standard electronic transactions in accordance with the appropriate HIPAA Implementation Guide
- When filing claims with NPIs, billing NPIs are always required, and rendering provider NPIs, when applicable, are also required
- Providers treating referred beneficiaries should also include the referring provider's NPI

HIPAA Transaction Standards and Code Sets

- **Providers must use the following HIPAA standard formats for TRICARE claims:**
  - ASC X12N 837 — Health Care Claim: Professional, Version 5010
  - ASC X12N 837 — Health Care Claim: Institutional, Version 5010
- TRICARE contractors and other health care payers are prohibited from accepting or issuing transactions that do not meet HIPAA standards
- **For assistance with HIPAA standard formats for TRICARE:** call PGBA's TRICARE Electronic Data Interchange (EDI) Help Desk at **1-800-325-5920**, menu option 2

Billing Tips

Claims can be delayed or denied for several reasons:

- Industry standard modifiers and condition codes may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing

- For billing tips to help facilitate prompt claims payments, see the ***TRICARE Provider Handbook***, available at **Humana-Military.com**

Electronic Claims Submission

- **XPressClaim** is available on myTRICARE.com
- **eZ TRICARE Claims** is available on Humana-Military.com
- **Claims clearinghouses** — check with your clearinghouse to find out what to do to send TRICARE claims to Humana Military (Find a current list of clearinghouses at Humana-Military.com)
- **PGBA's EDI Gateway** — use if your system can create HIPAA-compliant claims formats and you prefer to send claims directly to the payer
- **To enroll or learn more:** contact the TRICARE EDI Help Desk at **1-800-325-5920**, menu option 2

Electronic Remittance Advice (ERA) & Electronic Funds Transfer (EFT)

ERAs are the electronic equivalent of the Explanation Of Benefits (EOB)

- **PGBA offers two types of ERAs:** an imaged electronic payment voucher and a HIPAA-compliant 835 file
- ERAs offer secure information available to download or print at any time
- You can archive ERAs and 835 files for distribution or future reference
- ERAs are usually available the same day payment is made, and they save paper, time and office resources
- **EFT services** allow providers to receive funds through direct deposit up to three days sooner than paper checks

Enroll in EFT and ERA

1. Visit myTRICARE.com and select Provider Forms
2. Select the South Region
3. Click EFT/ERA Enrollment Form
4. Complete the registration form and print it
5. Fax the form to PGBA at 1-803-462-3995

TRICARE Reconsiderations/Claims Appeals

Participating providers may have claims reconsidered through medical review

- **Issues appropriate for medical review include:**
  - Requests for verification the edit was appropriately entered for the claim
  - Situations in which the provider submits additional documentation substantiating that unusual circumstances existed

- If a line on a claim is rejected, first review the medical documentation for any additional diagnosis and, if found, submit it as a Corrected Claim

TRICARE Reimbursement Methodologies

- **Reimbursement limitations:** Payments made to network providers for medical services rendered to TRICARE beneficiaries shall not exceed 100 percent of the TRICARE-allowable charge

- The TRICARE-allowable charge is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting

Resources & Contact Information

Humana Military

Self-Service for Providers at Humana-Military.com

- Sign up for our secure self-service portal for access to timely and efficient TRICARE transactions
- Verify beneficiary eligibility
- Enter new referrals and authorizations
- Check or update existing referrals and authorizations
- View pharmacy data by patient
- Look up codes
- Check the status of claims
- Check out the Guide to Self-Service for Providers to learn how to use this helpful tool

Provider Resources

Resource	Contact Information
Allowable charges	www.tricare.mil/cmac
Behavioral health care (ValueOptions)	Humana-Military.com 1-800-700-8646
Claims and EFT/ERA (PGBA)	myTRICARE.com 1-800-403-3950 1-800-325-5920, menu option 2 (EDI)
Fraud and abuse	1-800-333-1620 Humana-Military.com
Pharmacy services (Express Scripts)	1-877-363-1303 1-877-895-1900 (fax) www.express-scripts.com/TRICARE
Referrals and prior authorizations	Humana-Military.com
TRICARE For Life (TFL)	1-866-733-0404 1-866-773-0405 (TDD) www.TRICARE4U.com